

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04501

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET A. EMERY

2. Date of Death

Month  
FEB.Day  
3Year  
1999

3. Time of Death

3:15 AM

4a. Facility Name (If not institution, give street and number)

LAYHILL CENTER-GENESIS ELDERCARE

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

579-58-0066

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

6. Date of Birth

(Month, Day, Year)  
APR. 16, 1909

9. Birthplace (State or Foreign Country)

INDIANA

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3227 BEL PRE RD.

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COORDINATION DEPT. OF SPECIAL ASST. FOR POLICY

16b. Kind of Business/Industry

HEALTH EDUCATION AND WELFARE

17. Father's Name (First, Middle, Last)

DAVID T. EMERY

18. Mother's Name (First, Middle, Maiden Sumama)

CARRIE B. MILES

19a. Informant's Name/Relationship (Type, Print)

JUDITH SPRINGER/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9216 STERLING MONTAGUE DR., GREAT FALLS, VA. 22066

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

2/3/99

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

[Signature]

MOOO91

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician 2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

208381

29d. Date signed (Month, Day, Year)

February 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bessie Ann Arvin, 1811 Prince Philip Dr, Arlington

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the findings, and the potential for future research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main points of the report and a final conclusion about the overall findings.

6. The sixth part of the report is a list of references. It includes a list of all the sources used in the study, including books, articles, and other documents.

7. The seventh part of the report is a list of appendices. It includes a list of all the supplementary materials used in the study, including tables, figures, and other documents.

8. The eighth part of the report is a list of figures. It includes a list of all the figures used in the study, including graphs, charts, and other visual aids.

9. The ninth part of the report is a list of tables. It includes a list of all the tables used in the study, including data tables, summary tables, and other tables.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04502

Physician  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Charles Walter England

2. Date of Death

January 25, 1999

3. Time of Death

5:19 pm

4a. Facility Name (If not Institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

213-24-2875

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 5, 1899

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2030 Forest Hill Dr

10f. Zip Code

20903

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dairy Technologist

16b. Kind of Business/Industry

University of MD

17. Father's Name (First, Middle, Last)

C. Clifford England

18. Mother's Name (First, Middle, Maiden Surname)

Nettie May Clark

19a. Informant's Name/Relationship (Type, Print)

Edna S. England/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2030 Forest Hill Dr, Silver Spring, MD 20903

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cem

Date

Jan 29

20c. Location - City or Town, State

Adelphi, MD

21. Signature of Funeral Service Licensee

Alamy Dorell

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Ave, Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aortic Stenosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Frank N. Gravano, MD

29c. License number

D25080

29d. Date signed (Month, Day, Year)

1/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank N. Gravano, 10313 Georgia Ave, Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

Jennifer S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
**Certificate of Death** 99 04503

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Alejandro Luis Esquerre</b>				2. Date of Death Month Day Year <b>February 3, 1999</b>		3. Time of Death <b>0015</b>																	
4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>																	
5. Social Security Number <b>267-78-0499</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>September 28, 1917</b>																	
9. Birthplace (State or Foreign Country) <b>Cuba</b>																							
Usual Residence of Decedent																							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
10e. Street and Number <b>6312 Swords Way</b>				10f. Zip Code <b>20817</b>		10g. Citizen of What Country? <b>United States</b>																	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Cuban</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Optician</b>		16b. Kind of Business/Industry <b>Private Practice</b>																	
17. Father's Name (First, Middle, Last) <b>Alejandro Esquerre</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grazziella Beracierto</b>																			
19a. Informant's Name/Relationship (Type, Print) <b>Clara Couvillon/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6312 Swords Way, Bethesda, Maryland 20817</b>																			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		Date <b>February 4, 1999</b>		20c. Location - City or Town, State <b>Silver Spring, Maryland</b>																	
21. Signature of Funeral Service Licensee <i>Michael E. Higgins</i> M00846				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>																			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																							
<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">Immediate Cause (Final disease or condition resulting in death)</td> <td style="width: 40%; text-align: center;"><b>PNEUMONIA</b></td> <td style="width: 30%; text-align: right;">Approximate Interval Between Onset and Death</td> </tr> <tr> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td style="text-align: right;"><b>72 HS.</b></td> </tr> <tr> <td rowspan="3" style="vertical-align: middle;">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td style="text-align: center;"><b>IMMUNOSUPPRESSION</b></td> <td style="text-align: right;"><b>6 MONTHS</b></td> </tr> <tr> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;"><b>RECURRENT MALIGNANT LYMPHOMA</b></td> <td style="text-align: right;"><b>12 MONTHS</b></td> </tr> <tr> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	<b>PNEUMONIA</b>	Approximate Interval Between Onset and Death		Due to (or as a consequence of):	<b>72 HS.</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>IMMUNOSUPPRESSION</b>	<b>6 MONTHS</b>	Due to (or as a consequence of):		<b>RECURRENT MALIGNANT LYMPHOMA</b>	<b>12 MONTHS</b>		Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)	<b>PNEUMONIA</b>	Approximate Interval Between Onset and Death																					
	Due to (or as a consequence of):	<b>72 HS.</b>																					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>IMMUNOSUPPRESSION</b>	<b>6 MONTHS</b>																					
	Due to (or as a consequence of):																						
	<b>RECURRENT MALIGNANT LYMPHOMA</b>	<b>12 MONTHS</b>																					
	Due to (or as a consequence of):																						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																							
<b>PROSTATIC ADENOCARCINOMA WITH MULTIPLE BONE METASTASIS</b>																							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Michael E. Higgins</i>		29c. License number <b>023308</b>		29d. Date signed (Month, Day, Year) <b>FEB. 3, 1999</b>																	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>6410 ROCKLEDGE DR. #625 BETHESDA MD. 20817</b>																							
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature <i>Barbara B. Sparks</i>																					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Alejandro Luis Esquerre 2/3/1999  
 Division of Vital Records, P.O. Box 68760,  
 Baltimore, Maryland 21215-0020

12

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

04504

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Stella Fortune</b>				2. Date of Death Month <b>1</b> Day <b>24</b> Year <b>99</b>		3. Time of Death <b>10:00am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Heartland Health Care Of Hyattsville</b>				4b. City, Town, or Location of Death <b>Hyattsville</b>		4c. County of Death <b>Prince Georges</b>	
Funeral Director	5. Social Security Number <b>230-20-9441</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>6-21-11</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Md</b>	10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Hyattsville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>6500 Riggs Rd</b>				10f. Zip Code <b>20783</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> Collage (1-4or 5+)			18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>			16b. Kind of Business/Industry <b>Nursing</b>	
	17. Father's Name (First, Middle, Last) <b>Frank James</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Woods</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Ophelia J Thompson (cousin)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4200 12th St NE Wash DC 20017</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Alleghany Mem. Park</b>		Data <b>1-27-99</b>		20c. Location - City or Town, State <b>Covington Va</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>FRANK Miller Funeral Home 800 MAIN ST Clifton Forge Va</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease years</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>201852</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 10 1999</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul DeVore MD</b>							
31. Date filed (Month, Day, Year) <b>FEB 17 1999</b>		32. Registrar's Signature <i>[Signature]</i>						





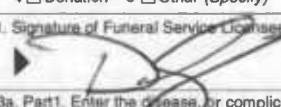
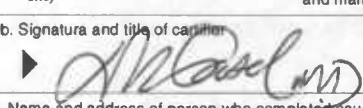
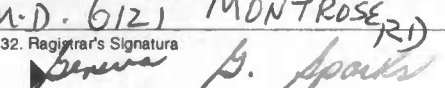
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

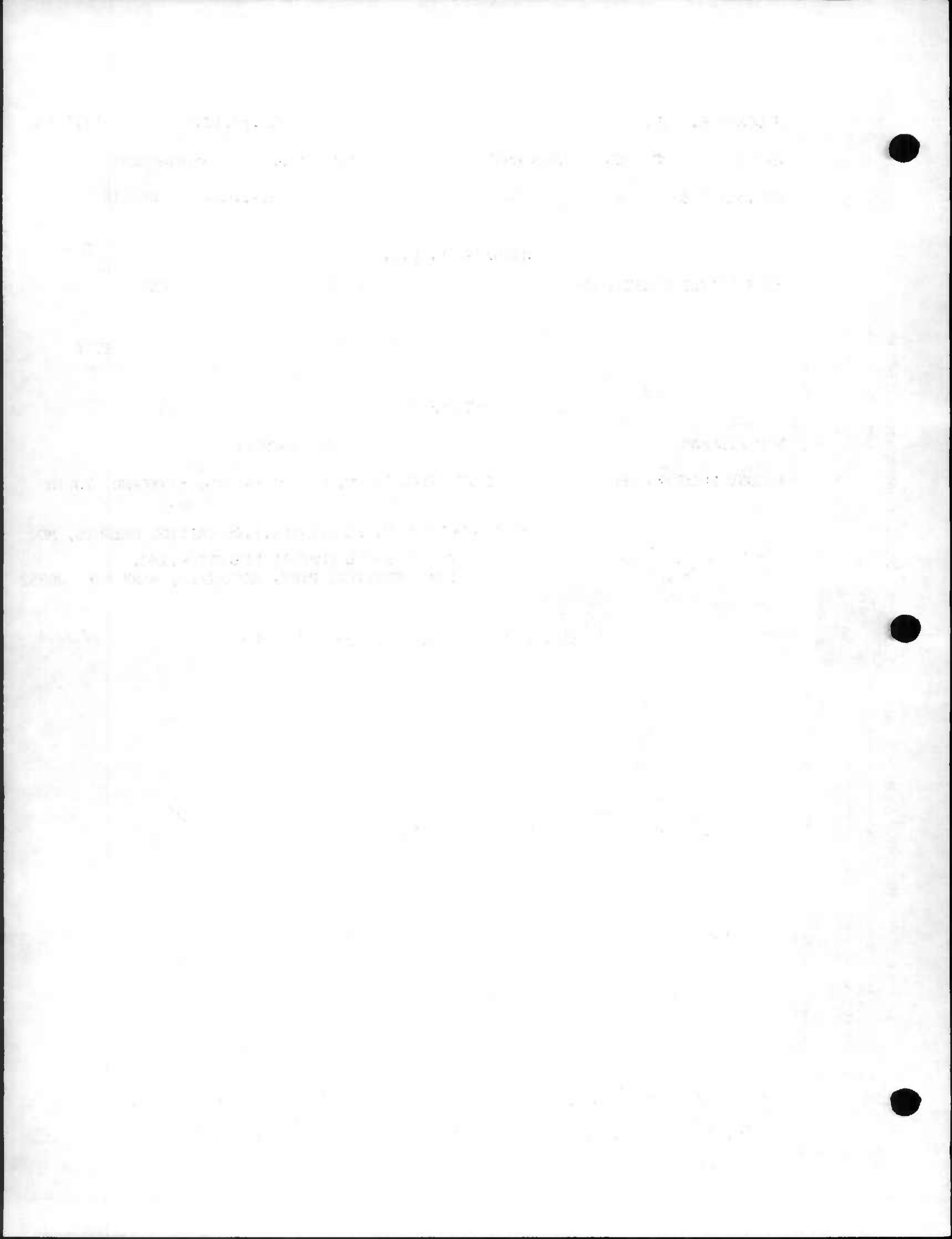
Reg. No.

99 04505

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SOLOMON H. FELDMAN</b>				2. Date of Death Month <b>01</b> Day <b>30</b> Year <b>1999</b>		3. Time of Death <b>11:15 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>HEBREW HOME OF GREATER WASHINGTON</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>579.52.4726</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>94</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>3.2.1904</b>		
	9. Birthplace (State or Foreign Country) <b>RUSSIA</b>		10a. State <b>MD</b>		10b. County <b>WASHINGTON, D.C.</b>		10c. City, Town or Location <b>WASHINGTON, D.C.</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3433 OLIVER STREET, NW</b>		10f. Zip Code <b>20015</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ATTORNEY</b>		16b. Kind of Business/Industry <b>LAW</b>		17. Father's Name (First, Middle, Last) <b>MAX FELDMAN</b>		18. Mother's Name (First, Middle, Maiden Summa) <b>IDA PINCHOOK</b>	
19a. Informant's Name/Relationship (Type, Print) <b>EDMUND FELDMAN/SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2227 RICHLAND ST, SILVER SPRING, MARYLAND 20910</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH SHOLOM CONG. CEMETERY</b>		20c. Location - City or Town, State <b>02.1.99 CAPITOL HEIGHTS, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Causa (Final disease or condition resulting in death) <b>a. Adenocarcinoma of Colon</b> Dua to (or as a consequence of):  <b>b. —</b> Dua to (or as a consequence of):  <b>c. —</b> Dua to (or as a consequence of):  <b>d. —</b>		Approximate Interval Between Onset and Death <b>1 MONTH</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Dementia, Vascular</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D18084</b>		29d. Date signed (Month, Day, Year) <b>January 31, 1999</b>			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852</b>		31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04506

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

SYLVIA FELDMAN

2. Date of Death  
Month Day Year  
02.02.1999

3. Time of Death  
10:30 PM

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

579.52.7218

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

10.31.1910

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedant

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6121 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedant's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

EDWARD FINGERHUT

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE "UNOBTAINABLE"

19a. Informant's Name/Relationship (Type, Print)

DR. MELVIN FELDMAN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12621 LAMPPOST LANE, POTOMAC, MARYLAND 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID MEMORIAL GDNS 2.5.99 FALLS CHURCH, VIRGINIA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Vascular dementia

Years

Due to (or as a consequence of):

b. Arteriosclerotic cardiovascular disease

Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Burt I. Feldman MD

29c. License number

D23958

29d. Date signed (Month, Day, Year)

2/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Burt I. Feldman MD, 6105 Montrose Rd., Rockville MD 20852

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



WRC  
99-0505-033  
WILLIAM S.  
FIELDS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2-18-99 WB

Certificate of Death

Reg. No.

ITEMS: #23 PART 1, 27, 28A-F PER MEO G768

99 04507

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) William S. Fields				2. Date of Death Month Day Year JANUARY 30, 1999				3. Time of Death 11:26 AM.	
4a. Facility Name (If not institution, give street and number) GREATER LAUREL HOSPITAL				4b. City, Town, or Location of Death LAUREL				4c. County of Death Prince Georges	
5. Social Security Number 052-64-0663		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 20 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 16, 1978		9. Birthplace (State or Foreign Country) New York	
Usual Residence of Decedent									
10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10a. Street and Number 3418 Robey Terrace				10f. Zip Code 20904		10g. Citizen of What Country? USA			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed			16b. Kind of Business/Industry N/A		
17. Father's Name (First, Middle, Last) James A. Fields				18. Mother's Name (First, Middle, Maiden Surname) Gail M. Lewis					
19a. Informant's Name/Relationship (Type, Print) James A. Fields (father)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 177-12 Sayers Avenue, Jamaica, NY 11433					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Calverton Natinal Cemetery		Date 2/9/99		20c. Location - City or Town, State Calverton, NY			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901					
23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  NARCOTIC INTOXICATION Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Found: 1-30-99		28b. Time of Injury Found: 10:40 A M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) UNKNOWN				28f. Location (Street and Number or Rural Route Number, City or Town, State) BURTONSVILLE MARYLAND	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JANUARY 31, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) FEB 02 1999		32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.









Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04509

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth J. Ford

2. Date of Death

February 3, 1999

3. Time of Death

3:53 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

214-03-9714

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 7, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2512 Randolph Road

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Gas Station

17. Father's Name (First, Middle, Last)

Thomas D. Ford

18. Mother's Name (First, Middle, Maiden Surname)

Lottie Fox

19a. Informant's Name/Relationship (Type, Print)

John C. Ford (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23741 Rolling Fork Way, Gaithersburg, MD 20882

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cemetery

Date

2/6/99

20c. Location - City or Town, State

Adelphi, MD

21. Signature of Funeral Service Licensee

James S. Dooley

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction

Approximate Interval Between Onset and Death

2 hours

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

10 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frank Gravino, MD

29c. License number

D25080

29d. Date signed (Month, Day, Year)

2/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank Gravino, MD; 10313 Georgia Ave; Silver Spring, MD

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

*[Faint, illegible text throughout the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]*



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04510

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SOPHIE FOX

2. Date of Death

JAN 28 99

3. Time of Death

7:35am

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

578-24-4088

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 14, 1925 Washington, D.C.

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10327 Champions Way

10f. Zip Code

20723

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Health Care Worker

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Christos Tames

18. Mother's Name (First, Middle, Maiden Surname)

Athena Tames

19a. Informant's Name/Relationship (Type, Print)

Kathryn Ann Fox (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3900 Cathedral Avenue, NW #702A Washington, DC 20016

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cemetery

Date

2/01/99

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minutes

b. END STAGE RENAL DISEASE

Due to (or as a consequence of):

2 years

c. LIVER FAILURE 2° TO HEPATITIS

Due to (or as a consequence of):

2 years

d. DIABETES

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D50616

29d. Date signed (Month, Day, Year)

JAN 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY A PIEPRZAK MD 716 MAIDEN CHOICE LANE BALTIMORE MD 21228

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04511

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Louise Freeburger				2. Date of Death Month Day Year January 29, 1999				3. Time of Death 7:30 p.m.															
	4a. Facility Name (If not institution, give street and number) Bedford Court				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery															
Funeral Director	5. Social Security Number 139-07-2681		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 24, 1907		9. Birthplace (State or Foreign Country) Maryland															
	Usual Residence of Decedent																							
To Be Completed by Funeral Director	10e. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No															
	10e. Street and Number 3700 International Drive				10f. Zip Code 20906		10g. Citizen of What Country? U.S.A.																	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White															
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4+ College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher				16b. Kind of Business/Industry Education															
	17. Father's Name (First, Middle, Last) William H. Freeburger				18. Mother's Name (First, Middle, Maiden Surname) Clara Putts																			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mildred V. Kraft/Half Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 37, Tall Timbers, MD 20690																			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore/Washington Crematory		Date 2/4/99		20c. Location - City or Town, State Laurel, Maryland																	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W., Washington, D.C. 20016																			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																							
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>Artherosclerotic Heart Disease</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td>years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	Artherosclerotic Heart Disease	Approximate Interval Between Onset and Death	Due to (or as a consequence of):		years	Due to (or as a consequence of):			Due to (or as a consequence of):			Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)	Artherosclerotic Heart Disease	Approximate Interval Between Onset and Death																						
Due to (or as a consequence of):		years																						
Due to (or as a consequence of):																								
Due to (or as a consequence of):																								
Due to (or as a consequence of):																								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation Urinary Tract Infection								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																								
29b. Signature and title of certifier 				29c. License number D3335-7		29d. Date signed (Month, Day, Year) 2/1/99																		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jonathan Lee Musher, M.D., 5530 Wisconsin Avenue, #1045, Chevy Chase, MD 20815																								
31. Date filed (Month, Day, Year) FEB 04 1999		32. Registrar's Signature 																						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04512

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

JOHNNIE

GARRETT

2. Date of Death

Month  
JANUARY

Day

28,

Year

1999

3. Time of Death

1820

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGE COMMUNITY HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGE

5. Social Security Number

577-52-6544

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

APRIL 10, 1938

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE

10c. City, Town or Location

LANDOVER

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3410 DODGE PARK ROAD #304

10f. Zip Code

20785

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HEAVY EQUIPMENT OPERATOR

16b. Kind of Business/Industry

PRIVATE INDUSTRY

17. Father's Name (First, Middle, Last)

STEVE GARRETT

18. Mother's Name (First, Middle, Maiden Surname)

ANNA PEARL BROADWATER

19a. Informant's Name/Relationship (Type, Print)

BETTY J. GARRETT /wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3410 DODGE PARK RD., #304, LANDOVER, MD. 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FOREST HILLS CEMETERY

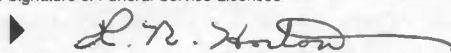
Data

2/8/99

20c. Location - City or Town, State

CLINTON, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

R. N. HORTON CO. MORTICIANS, INC.  
600 KENNEDY STREET, N.W., WASH., DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis  
Due to (or as a consequence of):b. Lung Carcinoma  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

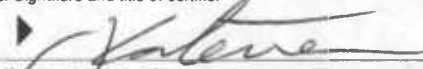
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D30318

29d. Date signed (Month, Day, Year)

1/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Katavenis, M.D., 3001 Hospital Drive, Cheverly, MD. 20785

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and is intended to give a general impression of the progress of the work.

2. The second part of the report deals with the results of the work done during the year. It is a summary of the results of the work and is intended to give a general impression of the progress of the work.

3. The third part of the report deals with the conclusions drawn from the work done during the year. It is a summary of the conclusions drawn from the work and is intended to give a general impression of the progress of the work.

4. The fourth part of the report deals with the recommendations made during the year. It is a summary of the recommendations made during the year and is intended to give a general impression of the progress of the work.

5. The fifth part of the report deals with the summary of the work done during the year. It is a summary of the work done during the year and is intended to give a general impression of the progress of the work.

6. The sixth part of the report deals with the summary of the work done during the year. It is a summary of the work done during the year and is intended to give a general impression of the progress of the work.

7. The seventh part of the report deals with the summary of the work done during the year. It is a summary of the work done during the year and is intended to give a general impression of the progress of the work.

8. The eighth part of the report deals with the summary of the work done during the year. It is a summary of the work done during the year and is intended to give a general impression of the progress of the work.

9. The ninth part of the report deals with the summary of the work done during the year. It is a summary of the work done during the year and is intended to give a general impression of the progress of the work.

10. The tenth part of the report deals with the summary of the work done during the year. It is a summary of the work done during the year and is intended to give a general impression of the progress of the work.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04513

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lillian A. Gengler</b>				2. Date of Death Month Day Year <b>January 31, 1999</b>				3. Time of Death <b>9:00 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Genesis Eldercare - Layhill Center</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>				4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>076-07-1797</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) <b>April 3, 1912</b>		9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Fulton</b>		
Usual Residence of Decedent											
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number <b>7518 Cherry Tree Drive</b>				10f. Zip Code <b>20759</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Traffic Operator</b>				16b. Kind of Business/Industry <b>Telephone Company</b>			
17. Father's Name (First, Middle, Last) <b>Angelo Falvo</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Nicolina Catalone</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Irene Brocenos (P.O.A.)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7518 Cherry Tree Lane, Fulton, MD 20759</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>				20c. Location - City or Town, State <b>2/3/99 Silver Spring, MD</b>			
21. Signature of Funeral Service Licensee <b>J. Keir Skiles</b>						22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Cause (Final disease or condition resulting in death) a. <b>CROWN DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>YEARS</b>											
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>DEMENTIA</b>											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <b>[Signature]</b>						29c. License number <b>D36046</b>		29d. Date signed (Month, Day, Year) <b>2/2/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN A. MERENDINO JR., MD</b>						<b>4701 RANDOLPH RD #216 ROCKVILLE, MD 20852</b>					
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>						32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 10a,b,d,e,f,g,per informant G789 11/6/00 yf

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Henry Joseph Gerardi</b>				2. Date of Death Month Day Year <b>January 31, 1999</b>		3. Time of Death <b>3:00 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>15301 Wallbrook Court, #2A</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>040-01-2655</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>February 8, 1914</b>	
9. Birthplace (State or Foreign Country) <b>Connecticut</b>		10a. State <b>Florida</b>		10b. County <b>Palm Beach</b>		10c. City, Town or Location <b>Silver Spring</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>5188 WoodLand Drive #132</b> <del>15301 Wallbrook Court, #2A</del>		10f. Zip Code <b>20906</b> 33418		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Golf Professional</b>		16b. Kind of Business/Industry <b>Golf</b>		17. Father's Name (First, Middle, Last) <b>Vincent Gerardi</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Esther Sasso</b>		19a. Informant's Name/Relationship (Type, Print) <b>H. Brooks Gerardi/ Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17099 Briardale Road, Rockville, Maryland 20855</b>		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		20c. Date <b>February 3, 1999</b>		20d. Location - City or Town, State <b>Bethesda, Maryland</b>		21. Signature of Funeral Service Licensee  <b>M00689</b>	
22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. <b>a. Pancreatic Cancer</b>		Approximate Interval Between Onset and Death <b>For Years</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
23c. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23d. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>February 3, 1999</b>	
28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D33686</b>	
29d. Date signed (Month, Day, Year) <b>February 1, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kenneth D. Miller, M.D. 18111 Prince Philip Dr., #327, Olney, MD 20832-1513</b>		31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

IDA C. GORDON

2. Date of Death

02.02.1999

3. Time of Death

4:30 PM

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville MD

4c. County of Death

Montgomery

5. Social Security Number

579.03.9185

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT 21, 1918

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6111 MONTROSE ROAD, APT 1011

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

N.A.S.A.

17. Father's Name (First, Middle, Last)

ISADORE HORVITZ

18. Mother's Name (First, Middle, Maiden Surname)

JENNY MILLMAN

19a. Informant's Name/Relationship (Type, Print)

SONNY GORDON/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10756 ROCHESTER AVE, LOS ANGELES, CA 90024

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

UNITED HEBREW CEMETERY

Date

2.5.99

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Perforated Ulcer  
Due to (or as a consequence of):  
b. Ischemic Colitis  
Due to (or as a consequence of):  
c.  
Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

2 days  
2 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetic Melitus

Pneumonia

Ischemic heart disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen Hellman 6240 Montrose Road Rockville Md 20852

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

Geneva B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 04516**  
**Certificate of Death**

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>LOUIS GRANT</b>				2. Date of Death Month <b>02</b> Day <b>03</b> Year <b>99</b>		3. Time of Death <b>14/30</b>		
	4a. Facility Name (If not institution, give street and number) <b>COLLINGSWOOD 299 HURLEY AVE</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>		
<b>Funeral Director</b>	5. Social Security Number <b>285-30-6053</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>05/05/23</b>	9. Birthplace (State or Foreign Country) <b>Jamaica</b>	
	Usual Residence of Decedent								
<b>To Be Completed by Funeral Director</b>	10a. State <b>Md</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>8314 Mountain Ash Way</b>				10f. Zip Code <b>20879</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sub- Contractor</b>				16b. Kind of Business/Industry <b>Housing- Construct</b>		
	17. Father's Name (First, Middle, Last) <b>Unk.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unk.</b>				
<b>To Be Completed by Physician/Medical Examiner</b>	19a. Informant's Name/Relationship (Type, Print) <b>Donovan Grant (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8314 Mountain Ash Way, Gaithersburg, Md 20879</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate Of Heaven Cem.</b>		Date <b>2/10/99</b>		20c. Location - City or Town, State <b>Silver Spring, Md</b>		
	21. Signature of Funeral Service Licensee <i>George R. Snowden</i>				22. Name and Address of Facility <b>Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Md</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Pancreatic cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							Approximate Interval Between Onset and Death <b>years</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>Patricia L. Tomsco, MD</b>				29c. License number <b>D-51916</b>		29d. Date signed (Month, Day, Year) <b>Feb 3, 1999</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr Patricia L. Tomsco M.D. 11140 Rockville Pike #348 Rockville, Md #20852</b>									
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>				32. Registrar's Signature <i>Benita B. Sparks</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04517

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPHINE WEAVER GRETZ</b>				2. Date of Death Month <b>FEB.</b> Day <b>2,</b> Year <b>1999</b>		3. Time of Death <b>9:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BRIGHTON GARDENS</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>184-30-0073</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>98</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 15, 1900</b>	
	9. Birthplace (State or Foreign Country) <b>PA.</b>		10a. State <b>MD.</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>BETHESDA</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>5550 TUCKERMAN LA.</b>			
	10f. Zip Code <b>20852</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>SECRETARY</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>		16b. Kind of Business/Industry <b>PUBLIC SCHOOLS</b>			
	17. Father's Name (First, Middle, Last) <b>WALTER WEAVER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET UNKNOWN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>RICHARD W. GRETZ/SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 1657, EDWARDS, CO. 81632</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		Date <b>2/3/99</b>		20c. Location - City or Town, State <b>RIVERDALE, MD.</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i> MO0091		22. Name and Address of Facility <b>CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>congestive heart failure</i> Due to (or as a consequence of): f. <i>chronic obstructive pulmonary disease</i> Due to (or as a consequence of): g. <i>pulmonary hypertension</i> Due to (or as a consequence of): h. <i>bronchial asthma</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Albert K. Lee MD</i>		29c. License number <b>D31282</b>		29d. Date signed (Month, Day, Year) <b>2/2/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>3218 Wisconsin Avenue, Suite 105 Bethesda, MD 20814</b>		31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>						
32. Registrar's Signature <i>[Signature]</i>		33. State Registrar <b>State Registrar</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



THE COURT REPORTER AND TRANSCRIBER

— SUBSCRIPTIONS —

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04518

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sister M. Gervase Grove, CSC				2. Date of Death Month Day Year Jan 27 1999				3. Time of Death 03:42pm						
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery						
Funeral Director	5. Social Security Number 286-48-5815		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 24, 1915		9. Birthplace (State or Foreign Country) Washington, DC						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location Kensington				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	10e. Street and Number 5000 Strathmore Avenue				10f. Zip Code 20895		10g. Citizen of What Country? USA								
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse			16b. Kind of Business/Industry Health Care							
	17. Father's Name (First, Middle, Last) James Francis Grove				18. Mother's Name (First, Middle, Maiden Surname) Mary Frances Elam										
	19a. Informant's Name/Relationship (Type, Print) Sister Marian Daniel, CSC				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5000 Strathmore Avenue, Kensington, MD 20895										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date 1/30/99		20c. Location - City or Town, State Silver Spring, MD								
	21. Signature of Funeral Service Licensee Eric S. Scarlo				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Pancreatic Adenocarcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 2 weeks				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier Jeffrey Indrisano MD		29c. License number D37975		29d. Date signed (Month, Day, Year) Jan 28 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Indrisano MD 10801 Lockwood Dr Silver Spring 20901															
31. Date filed (Month, Day, Year) FEB 01 1999		32. Registrar's Signature B. Sparks													



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Andromachy Harris</b>				2. Date of Death Month Day Year <b>January 28, 1999</b>				3. Time of Death <b>1:50 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Woodside Center</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>				4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>080-32-8124</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar. 17, 1907</b>		9. Birthplace (State or Foreign Country) <b>Greece</b>	

Funeral  
Director

Usual Residence of Decedent			10a. State <b>N/A</b>			10b. County <b>N/A</b>			10c. City, Town or Location <b>Washington, D.C.</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
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10e. Street and Number <b>2110 Bancroft Place, N.W.</b>			10f. Zip Code <b>20008</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
--	--	--	-------------------------------	--	--	--	--	--

11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
--	--	---	--	--	--	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>		16b. Kind of Business/Industry <b>Fur</b>	
---	--	--	--	--	--

17. Father's Name (First, Middle, Last) <b>Constantine Gueros</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Thomaii Bakalis</b>	
--	--	---	--

19a. Informant's Name/Relationship (Type, Print) (son) <b>Constantine D. Kyropoulos, M.D.</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2110 Bancroft Place, N.W. Washington, D.C. 20008</b>	
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20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Michael's Cemetery</b>		20c. Location - City or Town, State <b>02/01/99 Astoria, New York</b>	
--	--	---	--	--	--

21. Signature of Funeral Service Licensee <i>William L. Byrd</i>		22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Sil. Spr., MD 20901</b>	
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Dehydration</b> Due to (or as a consequence of): <b>b. Dementia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>DMF</b>	
---	--	--	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acute Hip Fracture 1/28/99</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
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24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
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27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Jan 20, 1999</b>		28b. Time of Injury <b>unk</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>unk</b>	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <b>nursing home</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>9101 2nd Avenue Silver Spring, MD 20910</b>	

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
--	--

29b. Signature and title of certifier <i>Dr. [Signature]</i>		29c. License number <b>1000428</b>		29d. Date signed (Month, Day, Year) <b>Jan 29, 1999</b>	
---	--	---------------------------------------	--	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>IRA N BRECHER MD DMK Silver Spring MD 20902</b>	
--	--

31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature <i>[Signature]</i>	
---	--	---	--

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04520

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MALCOLM ORVILLE HAYNES, SR.

2. Date of Death  
Month Day Year

FEBRUARY 2, 1999

3. Time of Death

9:47 A.M.

4a. Facility Name (If not institution, give street and number)

11247 WESTPORT DRIVE

4b. City, Town, or Location of Death

BOWIE

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

215-32-7775

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 22, 1935

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

BOWIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11247 WESTPORT DRIVE

10f. Zip Code

20720

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

FUNERAL ASSISTANT

16b. Kind of Business/Industry

FUNERAL INDUSTRY

17. Father's Name (First, Middle, Last)

CLIFTON HAYNES

18. Mother's Name (First, Middle, Maiden Surname)

MARY ELIZABETH WILSON

19a. Informant's Name/Relationship (Type, Print)

CARYLON J. HAYNES - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11247 WESTPORT DRIVE, BOWIE, MARYLAND 20720

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ARLINGTON NATIONAL CEMETERY 2-5-99 ARLINGTON, VIRGINIA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. MYELOFIBROSIS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

PANCREATIC INSUFFICIENCY

SPINAL STENOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D30361

29d. Date signed (Month, Day, Year)

FEBRUARY 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARGERY G. MYERS, WALTER REED ARMY MEDICAL CENTER, WASHINGTON, DC 20307

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

Margery G. Myers

Baltimore, Maryland 21215-0020

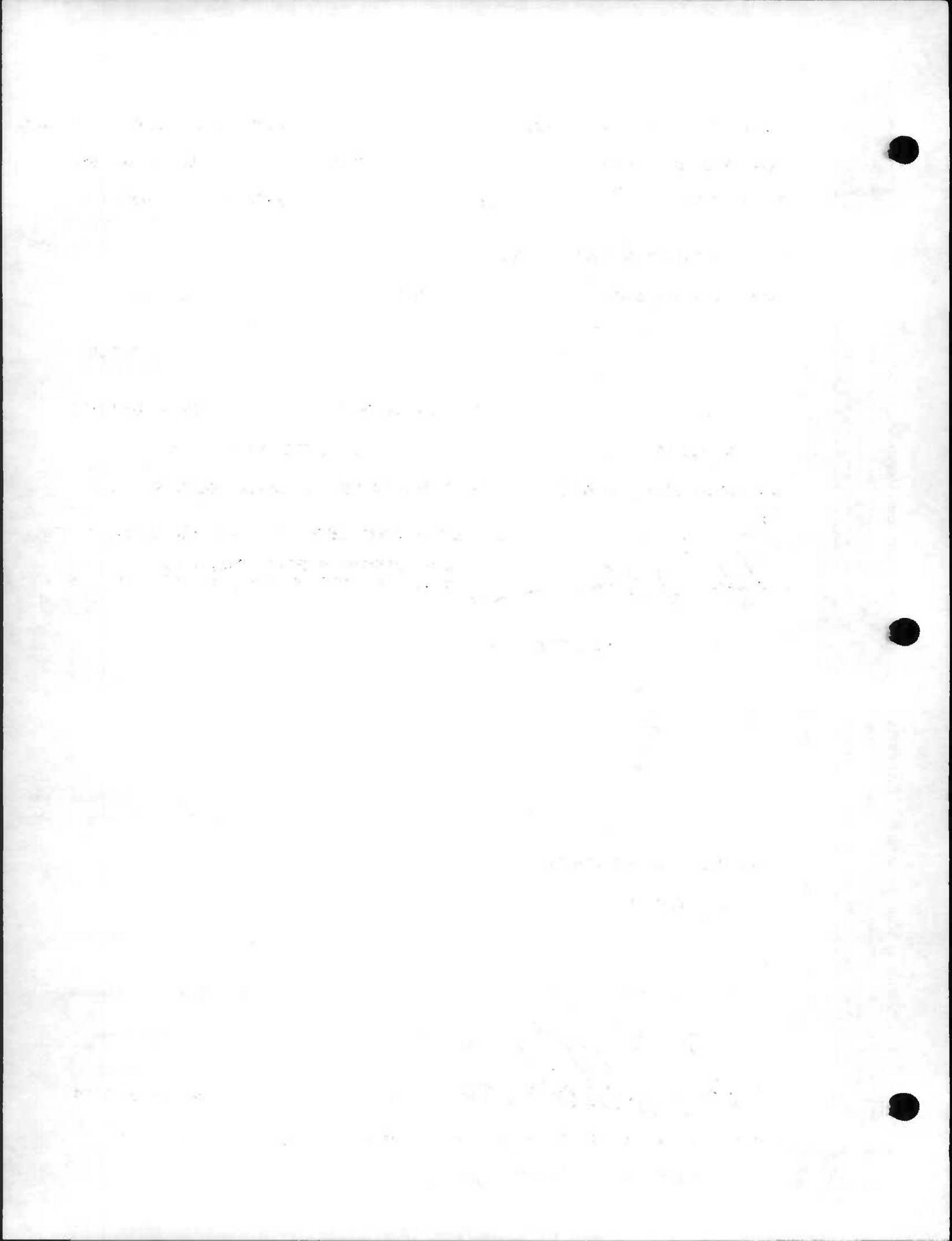
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-04521

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kathleen S. Heavey				2. Date of Death Month Day Year January 28, 1999				3. Time of Death 7:45 AM		
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 220-96-1758		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 27 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 12, 1971		9. Birthplace (State or Foreign Country) Washington, DC		
	Usual Residence of Decedent				10a. State MD		10b. County Montgomery		10c. City, Town or Location Rockville		
		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 14306 Parkmanor Terrace				10f. Zip Code 20853		10g. Citizen of What Country? USA	
		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher Assistant				16b. Kind of Business/Industry Education			
		17. Father's Name (First, Middle, Last) William J. Heavey				18. Mother's Name (First, Middle, Maiden Surname) Sharon F. Flanagan					
		19a. Informant's Name/Relationship (Type, Print) Sharon F. Heavey (mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14306 Parkmanor Terrace, Rockville, MD 20853					
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date 2/1/99		20c. Location - City or Town, State Silver Spring, MD			
		21. Signature of Funeral Service Licensee <i>James E. Ooley</i>				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Septic shock</i> Due to (or as a consequence of): b. <i>Acute Meningitis Bacterial</i> Due to (or as a consequence of): c. <i>Possb. Pulmonary Emboli</i> Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death  <i>sudden</i>  <i>sudden</i>  <i>sudden</i>	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>L. Ooley MD</i>				29c. License number D 31319		29d. Date signed (Month, Day, Year) 1-28-99	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Loreto ALBINO, MD 8218 Wisconsin Ave Bethesda, MD 20814</i>									
		31. Date filed (Month, Day, Year) FEB 01 1999				32. Registrar's Signature <i>Benita B. Sparks</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04522

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hugh Emmet Hegarty

2. Date of Death

Month Day Year  
January 30, 1999

3. Time of Death

4:45 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

152-07-5397

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 27, 1914

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15301 Beaverbrook Court, #3F

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Civil Engineer

16b. Kind of Business/Industry

United States Government

17. Father's Name (First, Middle, Last)

Anthony Francis Hegarty

18. Mother's Name (First, Middle, Maiden Summa)

Elizabeth Murphy

19a. Informant's Name/Relationship (Type, Print)

Helen J. Hegarty / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15301 Beaverbrook Court, #3F, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery

Date

February 8, 1999

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Barbara J. McMullen Lawrence

M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Acute aspiration pneumonia*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

48 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Arteriosclerotic Cardiovascular Disease*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Myron L. Lenkin MD

29c. License number

D06674

29d. Date signed (Month, Day, Year)

1/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myron L. LENKIN MD

2309 SHOREFIELD RD  
WHEATON MD 20902

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04523

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eileen Hensel

2. Date of Death

January 29, 1999

3. Time of Death

8:25 PM

4a. Facility Name (If not institution, give street and number)

Crofton Convalescent Center

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel County

Funeral  
Director

5. Social Security Number

217-44-2347

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 5, 1910

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

58-M Crescent Road

10f. Zip Code

20770

10g. Citizen of What Country?

United States

of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Department of  
Agriculture

17. Father's Name (First, Middle, Last)

Arthur A. McCaffrey

18. Mother's Name (First, Middle, Maiden Surname)

Emma R. Kelley

19a. Informant's Name/Relationship (Type, Print)

Richard T. Hensel

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19-C Parkway, Greenbelt, Maryland 20770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Union Dale Cemetery

Date

February

2, 1999

20c. Location - City or Town, State

Pittsburgh,

Pennsylvania

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Novack Funeral Home, Inc

3313 Brighton Road, Pittsburgh, Pennsylvania 15212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)a. Apnea  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death7 Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D32261

29d. Date signed (Month, Day, Year)

2-1-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard J. Edgar in 9500 Annapolis rd Lanthan md

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 03 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-7 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



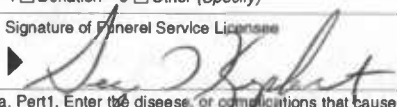
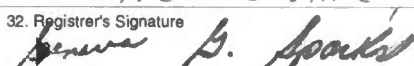
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04524

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Antha Joyce Howard</b>				2. Date of Death Month Day Year <b>January 29, 1999</b>		3. Time of Death <b>10:15 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Rockville MD</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>208-22-9295</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>October 25, 1930</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>5939 LeMay Road</b>				10f. Zip Code <b>20851</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Aide</b>			16b. Kind of Business/Industry <b>Day Care</b>	
17. Father's Name (First, Middle, Last) <b>Merlyn David Anderson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gladys Naomi Sellers</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Clayton Eugene Howard/ Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5939 LeMay Road Rockville, Maryland 20851</b>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>		
21. Signature of Funeral Service Licensee  M00335				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850</b>				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Ovarian Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>4 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  M.D.		29c. License number <b>037024</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 29, 1999</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID G. SNOOK, M.D. 9901 Medical Center Drive Rockville, Md. 20850</b>								
31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ANNE  
HUGENARD

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27 PER MEO G769 3-9-99 Certificate of Death

Reg. No.

99 04525

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>ANNE MARIE HUGENARD</b>				2. Date of Death Month Day Year <b>JANUARY 31, 1999</b>		3. Time of Death <b>8:47A.M.</b>							
4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>							
5. Social Security Number <b>312-32-2341</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb 5, 1932</b>							
9. Birthplace (State or Foreign Country) <b>Indiana</b>													
Usual Residence of Decedent													
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Germantown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number <b>13137 Dairymaid Drive, #104</b>				10f. Zip Code <b>20874</b>		10g. Citizen of What Country? <b>United States</b>							
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Teacher</b>		16b. Kind of Business/Industry <b>Education</b>									
17. Father's Name (First, Middle, Last) <b>Aaron H. Huguenard</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anne Marie McInerny</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Jane Mack, Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3335 LaSalle Trail, Michigan City, Indiana 46360</b>									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>Feb 3, 1999</b>		20c. Location - City or Town, State <b>Alexandria, Virginia</b>							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD 20877</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death											
	b. Due to (or as a consequence of):												
	c. Due to (or as a consequence of):												
	d. Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
						24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 1, 1999</b>							
30. Name and address of person who completed causa of death (Item 25a) (Type, Print) <b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>													
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature 											

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended#4aperPhy, #5, 10eperFHG768 2/26/99 EW

## Certificate of Death

Reg. No.

99 04526

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GIZZELLE LORRAINE HUTCHINSON</b>				2. Date of Death Month Day Year <b>FEB. 4, 1999</b>		3. Time of Death <b>12:00 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>300 Harford Street Apt 3-D <del>30 HARFORD ROAD</del></b>				4b. City, Town, or Location of Death <b>LA PLATA</b>		4c. County of Death <b>CHARLES</b>	
Funeral Director	5. Social Security Number <b>215-69-5224</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>45</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR 11 24, 1953</b>	
	9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>		10a. State <b>MARYLAND</b>		10b. County <b>CHARLES</b>		10c. City, Town or Location <b>LA PLATA</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>300 Harford Street Apt 3-D <del>30 HARFORD ROAD</del></b>		10f. Zip Code <b>20646</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DATA ENTRY</b>		16b. Kind of Business/Industry <b>BRANCH ELECTRIC CO.</b>			
	17. Father's Name (First, Middle, Last) <b>GEORGE LEROY POOLE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SYLVIA BENNETT</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>BRENDA IRVIN-SISTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3212 WESTDALE DRIVE WALDORF, MD. 20601</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>TRINITY MEM. GARDENS 2-8-99</b>		20c. Location - City or Town, State <b>WALDORF, MARYLAND</b>		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Michael O. Spauld</b>				22. Name and Address of Facility <b>RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Breast Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. }</b> Due to (or as a consequence of):  <b>c. }</b> Due to (or as a consequence of):  <b>d. }</b>				Approximate Interval Between Onset and Death <b>4 years</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Michael O. Spauld MD</b>		29c. License number <b>D46246</b>	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>FEB. 4, 1999</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>P.O. Box 115 WALDORF MD 20604</b>					
	31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature <b>B. Spauld</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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Amended Item #26, per Phy.  
2/3/99, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

99 04527

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES ROBERT HUBATKA III						2. Date of Death Month Day Year FEB 1 1999		3. Time of Death 2:56pm	
	4a. Facility Name (If not institution, give street and number) CARROLL COUNTY GENERAL HOSPITAL						4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL	
Funeral Director	5. Social Security Number 156-20-3356		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) MAR. 16, 1928		9. Birthplace (State or Foreign Country) NEW JERSEY	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County CARROLL		10c. City, Town or Location FINKSBURG				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 3304 TOGGENBURG DRIVE				10f. Zip Code 21048		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANICAL/ELEC. ENGINEER				16b. Kind of Business/Industry ELECTRONICS			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) CHARLES ROBERT HUBATKA, JR.						18. Mother's Name (First, Middle, Maiden Surname) DORIS ALTHEA PALEY			
	19a. Informant's Name/Relationship (Type, Print) DOROTHY HUBATKA/WIFE						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3304 TOGGENBURG DRIVE, FINKSBURG MD 21048			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) DUL. VALLEY MEM. GARD.		20c. Date 2/5/99		20d. Location - City or Town, State BALTIMORE, MARYLAND			
	21. Signature of Funeral Service Licensee <i>James L. Schen</i>						22. Name and Address of Facility 91 WILLIS STREET MYERS FUNERAL HOME WESTMINSTER, MD 21157			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <i>ventricular fibrillation</i> Due to (or as a consequence of): b. <i>Arteriosclerotic cardiovascular disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>5 years</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier <i>Christopher N. Nigam</i>		
29c. License number D18200								29d. Date signed (Month, Day, Year) 2/2/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHITRAKETHU NARANNA 700+ park Rd Westminister MD 21157										
State Registrar	31. Date filed (Month, Day, Year) FEB 03 1999				32. Registrar's Signature <i>B. Sparks</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04528

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RITA STARTT HILL						2. Date of Death Month Day Year JAN. 31 1999		3. Time of Death 12:55 PM	
	4a. Facility Name (If not institution, give street and number) 5 VICTORIA COURT						4b. City, Town, or Location of Death EASTON		4c. County of Death TALBOT	
Funeral Director	5. Social Security Number 213-05-6297		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82		8. Date of Birth (Month, Day, Year) MAY 20, 1916		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County TALBOT		10c. City, Town or Location EASTON				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 5 VICTORIA COURT				10f. Zip Code 21601		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 -0-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) J. HOWARD STARTT						18. Mother's Name (First, Middle, Maiden Surname) MARY SMITH			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) SUZAN L. NEWMAN / DAUGHTER						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 S. HARRISON ST., EASTON, MD 21601			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) SPRING HILL CEMETERY		Date 2-3-99		20c. Location - City or Town, State EASTON, MD	
	21. Signature of Funeral Service Licensee <i>M. E. Newman III</i>						22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>congestive heart failure</i></p> <p>Due to (or as a consequence of):</p> <p>b. <i>cardiomyopathy</i></p> <p>Due to (or as a consequence of):</p> <p>c. <i>ischemic heart disease</i></p> <p>Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death</p> <p><i>months</i></p> <p><i>years</i></p> <p><i>years</i></p> </div> </div>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>diabetes mellitus</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>M. D.</i>				29c. License number D25750		29d. Date signed (Month, Day, Year) 2/1/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. SANCHEZ MD 509 Edgewood Ave. Easton, MD 21601										
31. Date filed (Month, Day, Year) FEB 02 1999		32. Registrar's Signature <i>Beverly B. Sparks</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



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State of Maryland / Department of Health and Mental Hygiene 99 04529

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lillyan Ferne Jacobson				2. Date of Death Month Day Year January 30, 1999		3. Time of Death 7:00 AM	
	4a. Facility Name (If not institution, give street and number) 6676 Hillandale Road				4b. City, Town, or Location of Death Chevy Chase		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 129-30-3054	8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 5, 1912		9. Birthplace (State or Foreign Country) New Jersey
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Chevy Chase			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 6676 Hillandale Road			10f. Zip Code 20815		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Furniture Sales			
	17. Father's Name (First, Middle, Last) Lionel Johnson				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Rice			
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) M. Steve Jacobson (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2707 East West Highway, Chevy Chase, Maryland 20815			
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Riverside Cemetery		Date 2-2-99		20c. Location - City or Town, State Rochelle Park, New Jersey	
	21. Signature of Funeral Service Licensee  M00956				22. Name and Address of Facility Kapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cardiovascular Accident Due to (or as a consequence of): b. Arteriosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D0001601		29d. Date signed (Month, Day, Year) January 30, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank C. Blackburn, M.D., 5401 Western Avenue, NW, Washington, DC 20014								
31. Date filed (Month, Day, Year) FEB 01 1999		32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04530

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

DOROTHY ELIZABETH JAEGER

2. Date of Death  
Month Day Year  
JANUARY 30, 19993. Time of Death  
4:15 PM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY VILLAGE CARE &amp; REHAB. CENTER

4b. City, Town, or Location of Death

MONTGOMERY VILLAGE

4c. County of Death

MONTGOMERY

5. Social Security Number

060-01-8131

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 25, 1914

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19310 Club House Road

10f. Zip Code

20866

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

William Flynn

18. Mother's Name (First, Middle, Maiden Surname)

Anna Mullaney

19a. Informant's Name/Relationship (Type, Print)

Frederick H. Jaeger, husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19310 Club House Rd., Montgomery Village, MD 20886

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

Feb. 1, 1999

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 E. Deer Park Dr., Gaithersburg, MD 20877

23a. Pertinent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. congestive heart failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. atherosclerosis

Due to (or as a consequence of):

5 yrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alan R. Pollack MD

29c. License number

D 33443

29d. Date signed (Month, Day, Year)

February 1, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

809 Viers Mill Rd

Rockville, Md

Alan R. Pollack, MD

20851

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

Denise G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04531

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lynette E. James</b>				2. Date of Death Month Day Year <b>January 30, 1999</b>		3. Time of Death <b>10:53AM</b>									
	4a. Facility Name (If not institution, give street and number) <b>Doctors Community Hospital</b>				4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince Georges</b>									
Funeral Director	5. Social Security Number <b>577-34-7676</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 31, 1913</b>		9. Birthplace (State or Foreign Country) <b>British West Indies, Jamaica</b>								
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Adelphi</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
	10e. Street and Number <b>1904 Lebanon Street</b>				10f. Zip Code <b>20783</b>		10g. Citizen of What Country? <b>USA</b>									
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Embassy</b>		16b. Kind of Business/Industry <b>Government</b>									
	17. Father's Name (First, Middle, Last) <b>Alfred Diedrick</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Irene Karris</b>											
	19a. Informant's Name/Relationship (Type, Print) <b>Lloyd E. James, Sr. (husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1904 Lebanon Street, Adelphi, MD 20783</b>											
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		Date <b>2/3/99</b>		20c. Location - City or Town, State <b>Silver Spring, MD</b>									
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>													
	23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>RESPIRATORY FAILURE</b></td> <td>Approximate Interval Between Onset and Death <b>2 WEEKS</b></td> </tr> <tr> <td>b. <b>METABOLIC ENCEPHALOPATHY</b></td> <td><b>3 WEEKS</b></td> </tr> <tr> <td>c. _____</td> <td></td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>RESPIRATORY FAILURE</b>	Approximate Interval Between Onset and Death <b>2 WEEKS</b>	b. <b>METABOLIC ENCEPHALOPATHY</b>	<b>3 WEEKS</b>	c. _____		d. _____
Immediate Cause (Final disease or condition resulting in death)	a. <b>RESPIRATORY FAILURE</b>	Approximate Interval Between Onset and Death <b>2 WEEKS</b>														
	b. <b>METABOLIC ENCEPHALOPATHY</b>	<b>3 WEEKS</b>														
	c. _____															
	d. _____															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PELVIC ABSCESS</b> <b>HEPATIC INSUFFICIENCY</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of Certifier  MD		29c. License number <b>D04899</b>		29d. Date signed (Month, Day, Year) <b>1/31/99</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Hand 4203 QUEENSBURY ROAD HYATTSVILLE, MD 20781</b>																
31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>		32. Registrar's Signature 														

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04532

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Maria

Jimenez

2. Date of Death

January 29

1999

3. Time of Death

12 noon

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF KENSINGTON

4b. City, Town, or Location of Death

KENSINGTON

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

579-05-1163

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCTOBER 12, 1903

9. Birthplace (State or Foreign Country)

PANAMA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2202 STANLEY AVENUE

10f. Zip Code

20851

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)XX Yes 2 ☐ No Specify: PANAMANIAN14. Race - American Indian,  
Black, White, etc.

Specify: HISPANIC

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

MANUEL S. ALVAREZ

18. Mother's Name (First, Middle, Maiden Surname)

ANDREA BATISTA

19a. Informant's Name/Relationship (Type, Print)

MARIA ACQUAVIVA/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2202 STANLEY AVENUE ROCKVILLE, MD 20851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

CEDAR HILL CEMETERY

Date

2/3/99

20c. Location - City or Town, State

SUITLAND, MD

21. Signature of Funeral Service Licensee

Anthony S. Dimmy

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebrovascular Accident

1992

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

1992

Due to (or as a consequence of):

c. Hypothyroidism

1992

Due to (or as a consequence of):

d. Alzheimer's Disease

1992

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MBP Strubbs MD

29c. License number

D17729

29d. Date signed (Month, Day, Year)

1/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 B. Patricia MD 4251 Corville Rd SJ, MD 20910

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #26, 2/4/99, BMW, Montg. Co per M.D.

Certificate of Death

Reg. No.

09 04533

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH STEELE JOHNSON

2. Date of Death

Month Day Year  
January 25, 1999

3. Time of Death

10:30 AM

4a. Facility Name (If not institution, give street and number)

3228 Henson Avenue

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

107-14-3289

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 22, 1910

9. Birthplace (State or Foreign Country)

Colorado

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☐ Yes 2 ☐ No

10e. Street and Number

5003 8th Street, N.W.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Native American /  
Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Executive assistant to Dean-School of Music

16b. Kind of Business/Industry

Howard University

17. Father's Name (First, Middle, Last)

Noble Steele

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Brandon

19e. Informant's Name/Relationship (Type, Print)

Barbara Maginley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3228 Henson Avenue, Annapolis, MD

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Cemetery

Date

1/30/99

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Thomas H. Chyburn

22. Name and Address of Facility

McGuire Funeral Service, Inc.  
7400 Georgia Ave. N.W., Washington, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arrhythmia

Due to (or as a consequence of):

10 min

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aortic Valve disease

Due to (or as a consequence of):

5 yr

c. thrombocytosis

Due to (or as a consequence of):

5 yr

d. Myeloproliferative disease

5 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) daughter's residence

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ellen Yang M.D.

29c. License number

D52170

29d. Date signed (Month, Day, Year)

1/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Bestgate Rd Suite 300 Annapolis MD 21401

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 04534

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roland N. Jordan						2. Date of Death Month Day Year Feb. 02 1999		3. Time of Death 1340	
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital						4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 213-05-0606		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 23, 1911		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 4105 Winfield Way				10f. Zip Code 21157		10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Charge of security			16b. Kind of Business/Industry Railway Express Agency			
17. Father's Name (First, Middle, Last) Herbert Jordan						18. Mother's Name (First, Middle, Maiden Surname) Cecelia Martin				
19a. Informant's Name/Relationship (Type, Print) Ruth Jordan Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4105 Winfield Way Westminster, MD 21157						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Dillsburg Cemetery		Date 2/5/99		20c. Location - City or Town, State Dillsburg, PA		
21. Signature of Funeral Service Licensee <i>Jane B. Corry</i>				22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Myocardial Infarction Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure										
23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Herbert P. Henderson Jr.</i>				29c. License number 00051924		29d. Date signed (Month, Day, Year) 2-3-99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herbert P. Henderson Jr. MD 295 Stoner Ave Suite 307 Westminster MD 21157										
31. Date filed (Month, Day, Year) FEB 03 1999		32. Registrar's Signature <i>B. Sparks</i>								





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04535

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ida Kaminsky

2. Date of Death

01 Month 31 Day 1999 Year

3. Time of Death

2:43AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

088 05 9616

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

07 08 1913

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6111 Montrose Rd #1010

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Louis Sallack

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Finkelstein

19a. Informant's Name/Relationship (Type, Print)

Arlene Kaminsky DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

45 Abbey Road, Fairfield, Conn 06430

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Eden Cemetery

Date

2-3-1999

20c. Location - City or Town, State

Hawthorne, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Danzansky-Goldberg Mem. Chapels, Inc

1170 Rockville Pike, Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

minutes

Due to (or as a consequence of):

b. Pneumonia

days

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin Dependent Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Katharine R. Lillie MD

29c. License number

53244

29d. Date signed (Month, Day, Year)

January 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Katharine R. Lillie, MD, 11140 Rockville Pike #348, Rockville, MD 20852

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Kaminsky, IDA  
1/31/99 0243  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04536

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

KEE CHUL KANG

2. Date of Death

Month Day Year  
JANUARY 25, 1999

3. Time of Death

5:30AM

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville MD

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

212-94-4383

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
NOV. 2, 1908

9. Birthplace (State or Foreign Country)

KOREA

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

GAITHERSBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17060 KING JAMES WAY APT. #614

10f. Zip Code

20877

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

KI SOO PARK

18. Mother's Name (First, Middle, Maiden Surname)

PUN YI CHO

19a. Informant's Name/Relationship (Type, Print)

SUN JIN KANG/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12600 CARRINGTON HILL DR. GAITHERSBURG, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NORBECK MEMORIAL PARK

Date

1/27/99

20c. Location - City or Town, State

OLNEY, MD

21. Signature of Funeral Service Licensee

Anthony J. Dymally

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Myocardial Infarction

Due to (or as a consequence of):

b.

Pneumonia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 days

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David A Holden MD

29c. License number

D47791

29d. Date signed (Month, Day, Year)

January 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David A Holden MD 809 Veirs Mill Rd, Rockville MD 20851

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04537

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

CORINNE Q. KENT

2. Date of Death

Month Day Year  
JANUARY 31, 1999

3. Time of Death

2:40PM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGE COMMUNITY HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGE

5. Social Security Number

579-30-0582

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
MARCH 2, 1927

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE

10c. City, Town or Location

CAPITOL HEIGHTS

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

914 CAPITAL HEIGHTS BOULEVARD

10f. Zip Code

20743

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ELEVATOR OPERATOR

16b. Kind of Business/Industry

PRIVATE INDUSTRY

17. Father's Name (First, Middle, Last)

RANDOLPH THOMPSON

18. Mother's Name (First, Middle, Maiden Surname)

CORA JOHNSON

19a. Informant's Name/Relationship (Type, Print)

JOHN H. KENT /husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

914 CAPITAL HGTS. BLVD., CAPITAL HGTS., MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT. LINCOLN CEMETERY

Date

2/6/99

20c. Location - City or Town, State

BRENTWOOD, MD.

21. Signature of Funeral Service Licensee

R. N. Horton

22. Name and Address of Facility

R. N. HORTON CO. MORTICIANS, INC.

600 KENNEDY STREET, N.W., WASH., DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

acute ventricular tachycardia

minutes

Due to (or as a consequence of):

b.

Acute myocardial infarction

minutes

Due to (or as a consequence of):

c.

Diffuse coronary atherosclerosis

years

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure, Hypertension  
pericardial fibroblastosis, sinus  
node dysfunction, malnutrition, pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. N. Horton MD

29c. License number

D24720

29d. Date signed (Month, Day, Year)

2-01-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAVINDER K. RUSTAGI  
6132 Landover Road, Cheverly MD 20785

31. Date filed (Month, Day, Year)

FEB 03 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

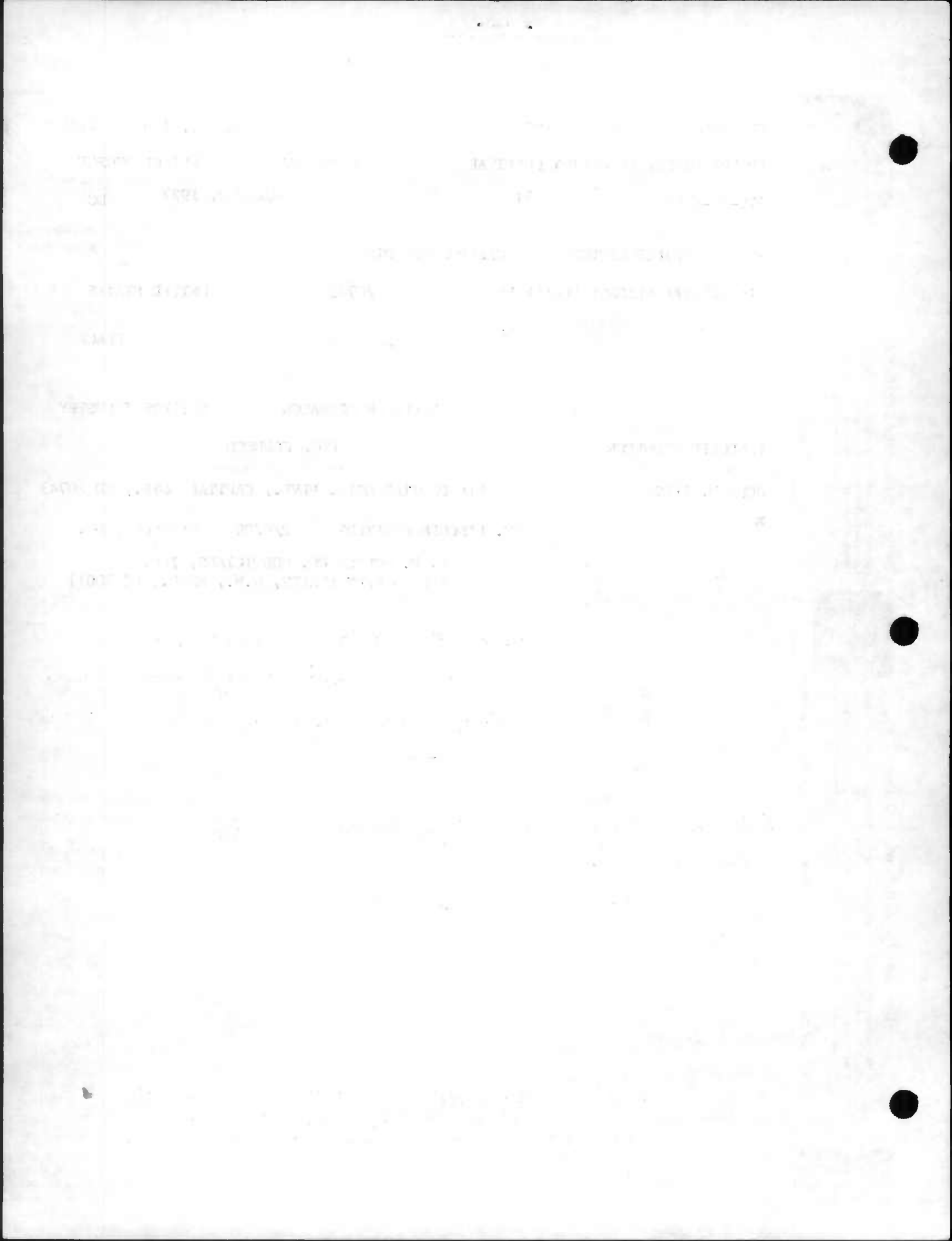
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04538

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Kleban</b>				2. Date of Death Month Day Year <b>February 3, 1999</b>		3. Time of Death <b>7:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>171-01-5771</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 5, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>Pa.</b>		10b. County <b>Luzerne</b>		10c. City, Town or Location <b>Hazleton</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>884 N. Laurel St.</b>		10f. Zip Code <b>18201</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Resturant Owner</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Food Service</b>		16b. Kind of Business/Industry <b>Food Service</b>				
17. Father's Name (First, Middle, Last) <b>Stanley Perchak</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Golab</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mary Offenheiser (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4032 Fragile Fail Way, Ellicott City, Md. 21042</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Calvary Cemetery</b>		20c. Date <b>2/6/99</b>		20d. Location - City or Town, State <b>Drums, Pa.</b>		
21. Signature of Funeral Service Licensee <b>Thomas S. Chamber</b> # 670				22. Name and Address of Facility <b>Chambers Funeral Homes, P.A. 5801 Cleveland Ave. Riverdale, Md. 20737</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Coronary Artery Disease</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>James R. Carroll, MD</b>		29c. License number <b>44571</b>		29d. Date signed (Month, Day, Year) <b>February 3, 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. James Cockrell, M.D. 7600 Carroll Ave. Takoma Park, Md. 20912</b>								
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature <b>James B. Sparks</b>						

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

100

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• **Security** – Confidentiality and integrity



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04539

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marion B. Klink

2. Date of Death

February 3, 1999

3. Time of Death

12:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Woodside Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

197-10-6888

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Dec. 13, 1909

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1013 Noyes Drive

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Musician

16b. Kind of Business/Industry

Entertainment

17. Father's Name (First, Middle, Last)

Robert N. Black

18. Mother's Name (First, Middle, Maiden Surname)

Mariah McDevitt

19a. Informant's Name/Relationship (Type, Print)

Robert Norman Klink (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22305 Rolling Hill Lane, Laytonsville, MD 20882

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

West Laurel Hill Cemetery 2/5/99

Date

20c. Location - City or Town, State

Bala Cynwyd, PA

21. Signature of Funeral Service Licensee

J. Kevin Gutowski

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Atherosclerosis of Coronary Arteries

Approximate Interval Between Onset and Death

1998

Due to (or as a consequence of):

b. Chronic Renal Disease

1999

Due to (or as a consequence of):

c. Grand mal Seizures

1999

Due to (or as a consequence of):

d. Hypertension

1999

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Kevin Gutowski MD

29c. License number

D 07729

29d. Date signed (Month, Day, Year)

2-3-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GB Patrick MD 9221 Coleridge Rd SE, MD 20910

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Andrew Krucelyak</b>		2. Date of Death Month <b>Jan.</b> Day <b>31</b> Year <b>1999</b>		3. Time of Death <b>4:05P.</b>	
4a. Facility Name (If not institution, give street and number) <b>Manor Care Health Services</b>			4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>
5. Social Security Number <b>578-07-3882</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Jan. 9, 1914</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>College Park</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>5906 Bryn Mawr Road</b>			10f. Zip Code <b>20740</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Iron Worker</b>		16b. Kind of Business/Industry <b>Local #201</b>
17. Father's Name (First, Middle, Last) <b>Stephan Krucelyak</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Julianna Brudnyak</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Irene K. Ferber (niece)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Peter and Paul Cemetery</b>		20c. Location - City or Town, State <b>Adrian, Pennsylvania</b>	
21. Signature of Funeral Service Licensee <b>Donald V. Borgwardt</b>		22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Pacemaker for Arrhythmia</b> Due to (or as a consequence of): b. <b>Alzheimer disease</b> Due to (or as a consequence of): c. <b>B.P.H.</b> Due to (or as a consequence of): d. <b>Anaemia</b>					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Kirti Vohra M.D.</b>		29c. License number <b>D-20274</b>		29d. Date signed (Month, Day, Year) <b>February 1, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kirti Vohra, M.D. 1299 Lambertson Dr. Silver Spring, Maryland 20902-3411</b>					
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature <b>G. Sparks</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04541

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Betty Lee Kenton</u>				2. Date of Death Month Day Year <u>January 28 1999</u>				3. Time of Death <u>11:18 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Memorial Hospital at Easton</u>				4b. City, Town, or Location of Death <u>Easton</u>				4c. County of Death <u>Talbot</u>	
Funeral Director	5. Social Security Number <u>215-26-2681</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>69</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>MAR. 22, 1929</u>		9. Birthplace (State or Foreign Country) <u>MD</u>	
	Usual Residence of Decedent				10a. State <u>MD</u>		10b. County <u>CAROLINE</u>		10c. City, Town or Location <u>PRESTON</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <u>2968 HUNTING CREEK ROAD</u>				10f. Zip Code <u>21655</u>	
	10g. Citizen of What Country? <u>USA</u>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11</u> College (1-4 or 5+) <u>0</u>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>FOOD SERVICE</u>				16b. Kind of Business/Industry <u>FOOD</u>				17. Father's Name (First, Middle, Last) <u>JOHN ENGERMAN</u>	
	18. Mother's Name (First, Middle, Maiden Surname) <u>LELA TODD</u>				19a. Informant's Name/Relationship (Type, Print) <u>HUSBAND</u> <u>CHARLES H. KENTON-</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2968 HUNTING CREEK RD, PRESTON, MD 21655</u>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>JUNIOR ORDER CEM. 2-1-99 PRESTON, MD.</u>				20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>WILLIAMSON FUNERAL HOME</u> <u>FEDERALSBURG MD 21632</u>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>pulmonary embolism</u> Due to (or as a consequence of):  b. <u>status post lumbar decompression &amp; fusion</u> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier <u>[Signature]</u>				29c. License number <u>D43197</u>				29d. Date signed (Month, Day, Year) <u>1-28-99</u>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>BENJAMIN D KNOX, 510 IDLEWILD AVE, EASTON, MD 21601</u>										
31. Date filed (Month, Day, Year) <u>FEB 04 1999</u>				32. Registrar's Signature <u>[Signature]</u>						

Kenton, Betty L.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04542

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Edward B Lenz 2. Date of Death Month February Day 2 Year 1999 3. Time of Death 0424

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital 4b. City, Town, or Location of Death Rockville 4c. County of Death Montgomery

5. Social Security Number 577-34-9984 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 93 Yrs. 8. Date of Birth (Month, Day, Year) Sept. 29, 1905 9. Birthplace (State or Foreign Country) Virginia

Usual Residence of Decedent

10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Rockville 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 813 Crothers Lane 10f. Zip Code 20852 10g. Citizen of What Country? United States

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Branch Chief 16b. Kind of Business/Industry Federal Government

17. Father's Name (First, Middle, Last) Justus Lenz 18. Mother's Name (First, Middle, Maiden Surname) Emma Weber

19a. Informant's Name/Relationship (Type, Print) Clare L. Lenz/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Crothers Lane, Rockville, Maryland 20852

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery Data Feb. 4, 1999 20c. Location - City or Town, State Silver Spring, Maryland

21. Signature of Funeral Service Licensee [Signature] M00198 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Intracerebral Hemorrhage Due to (or as a consequence of): 10 hours b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicidal 4 Homicidal 5 Pending investigation 8 Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier [Signature] 29c. License number D47791 29d. Date signed (Month, Day, Year) February 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David A Holden MD 809 Veirs Mill Rd Rockville MD 20851

State  
Registrar

31. Date filed (Month, Day, Year) FEB 05 1999 32. Registrar's Signature [Signature]

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARTHUR LOESERMAN						2. Date of Death Month Day Year FEBRUARY 2, 1999		3. Time of Death 8:05 PM	
	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL						4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 132-09-6091		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) OCTOBER 4, 1904		9. Birthplace (State or Foreign Country) NEW YORK	
	Usual Residence of Decedent									
10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 6111 MONTROSE ROAD				10f. Zip Code 20852				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: XX				14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MUSICIAN				16b. Kind of Business/Industry CLASSICAL VIOLINIST		
17. Father's Name (First, Middle, Last) FERDMAND LOESERMAN						18. Mother's Name (First, Middle, Maiden Surname) SADIC MEYER				
19a. Informant's Name/Relationship (Type, Print) RUTH LOESERMAN (WIFE)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6111 MONTROSE ROAD #921 ROCKVILLE MD 20852				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) UNION FIELDS CEMETERY		Date 2/5/99		20c. Location - City or Town, State RIDGEWOOD NEW YORK		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPEL 1170 ROCKVILLE PIKE ROCKVILLE MD 20852						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)										SUDDEN
a. RESPIRATORY FAILURE Due to (or as a consequence of):										TWO WEEKS
b. BILATERAL PNEUMONIA Due to (or as a consequence of):										THREE WEEKS
c. MASSIVE MYOCARDIAL INFRACTION Due to (or as a consequence of):										THREE YEARS
d. ATRIEL FIBULATION										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D20065		29d. Date signed (Month, Day, Year) FEBRUARY 3, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EVA M. MORELL 6000 EXECUTIVE BOULEVARD #300 ROCKVILLE MD 20852										
31. Date filed (Month, Day, Year) FEB 04 1999		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marie L. Lozupone

2. Date of Death

Jan 28 1999

3. Time of Death

1940

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-01-9358

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 22, 1914

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8800 Daimler Court

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

(Not Available)

Lingebach

18. Mother's Name (First, Middle, Maiden Surname)

Rosie Mineberg

19a. Informant's Name/Relationship (Type, Print)

Carol A. Kenefick/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8800 Daimler Court, Potomac, Maryland 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

February 1, 1999

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

D. A. Pumphrey M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue  
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. fracture left femur

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

DMF

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

Jan 25, 1999

28b. Time of  
Injury

PM M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Self in Nurs. Home

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

Nursing Home

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)3616 Littledale Rd  
Kensington, MD 2089529a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. A. Pumphrey M DMF

29c. License number

D00428

29d. Date signed (Month, Day, Year)

Jan 29, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

IRA N BRECKER, M DMF

2101 Medical Park Dr  
Silver Spring MD 20902

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

199 04545

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cora Emma Little

2. Date of Death

Month Day Year  
Feb. 8, 1999

3. Time of Death

5:15 PM

4a. Facility Name (If not institution, give street and number)

2906 Lieb Road

4b. City, Town, or Location of Death

Parkton

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

166-12-7278

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 29, 1920

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Parkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2906 Lieb Road

10f. Zip Code

21120

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Alvin E. Rohdes

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Witmyer

19a. Informant's Name/Relationship (Type, Print)

Albert B. Little/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

716 Davis Rd., Stewartstown, PA 17363

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Yorktowne Caskets, Inc. Cremation Service

Date

Feb. 10, 1999

20c. Location - City or Town, State

York, PA 17404

21. Signature of Funeral Service Licensee

*J.J. Hartenstein*

22. Name and Address of Facility

J.J. Hartenstein Mortuary, Inc. 19 S. Main St., Stewartstown, PA 17363

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arterio Sclerotic Cardio Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Charles F. O'Donnell MD*

29c. License number

D-09383

29d. Date signed (Month, Day, Year)

2-9-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles F. O'Donnell MD - 716 Hamlet Hill Rd Baltimore MD 21210

31. Date filed (Month, Day, Year)

FEB 17 1999

32. Registrar's Signature

*Geneva B. Sparks*

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04546

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ISABELLE ROBINSON MACKEY</b>				2. Date of Death Month Day Year <b>JANUARY 30, 1999</b>		3. Time of Death <b>3:37 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>WILSON HEALTH CARE CENTER AT ASBURY VILLAGE</b>				4b. City, Town, or Location of Death <b>GAITHERSBURG</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>281-22-5674</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 24, 1908</b>		
	9. Birthplace (State or Foreign Country) <b>Ohio</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>403 Russell Avenue, #706</b>		10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>2</b>		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Tax Assessor</b>		16b. Kind of Business/Industry <b>City of Newton, Massachusetts</b>					
17. Father's Name (First, Middle, Last) <b>John Robinson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ida Ross</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Faith Holland, Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6 Upland Road, Apt. F4 Baltimore, MD 21210</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Old Washington Cemetery</b>		Date <b>Feb 6, 1999</b>		20c. Location - City or Town, State <b>Old Washington, Ohio</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DeVol Funeral Home</b> <b>10 East Deer Park Dr., Gaithersburg, MD 20877</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. cerebral edema</b> Due to (or as a consequence of): <b>b. Hypertensive intracerebral Hemorrhage</b> Due to (or as a consequence of): <b>c. Hypertension</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>weeks</b> <b>months</b> <b>years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>degenerative arthritis</b> <b>mild dementia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>P. Callahan-Lyon MD</b>		29c. License number <b>041794</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 1, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>911 Russell Ave Gaithersburg, MD 20879</b>		31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature 		33. Registrar's Name <b>P. Callahan-Lyon, MD</b>			

To Be Completed by Funeral Director

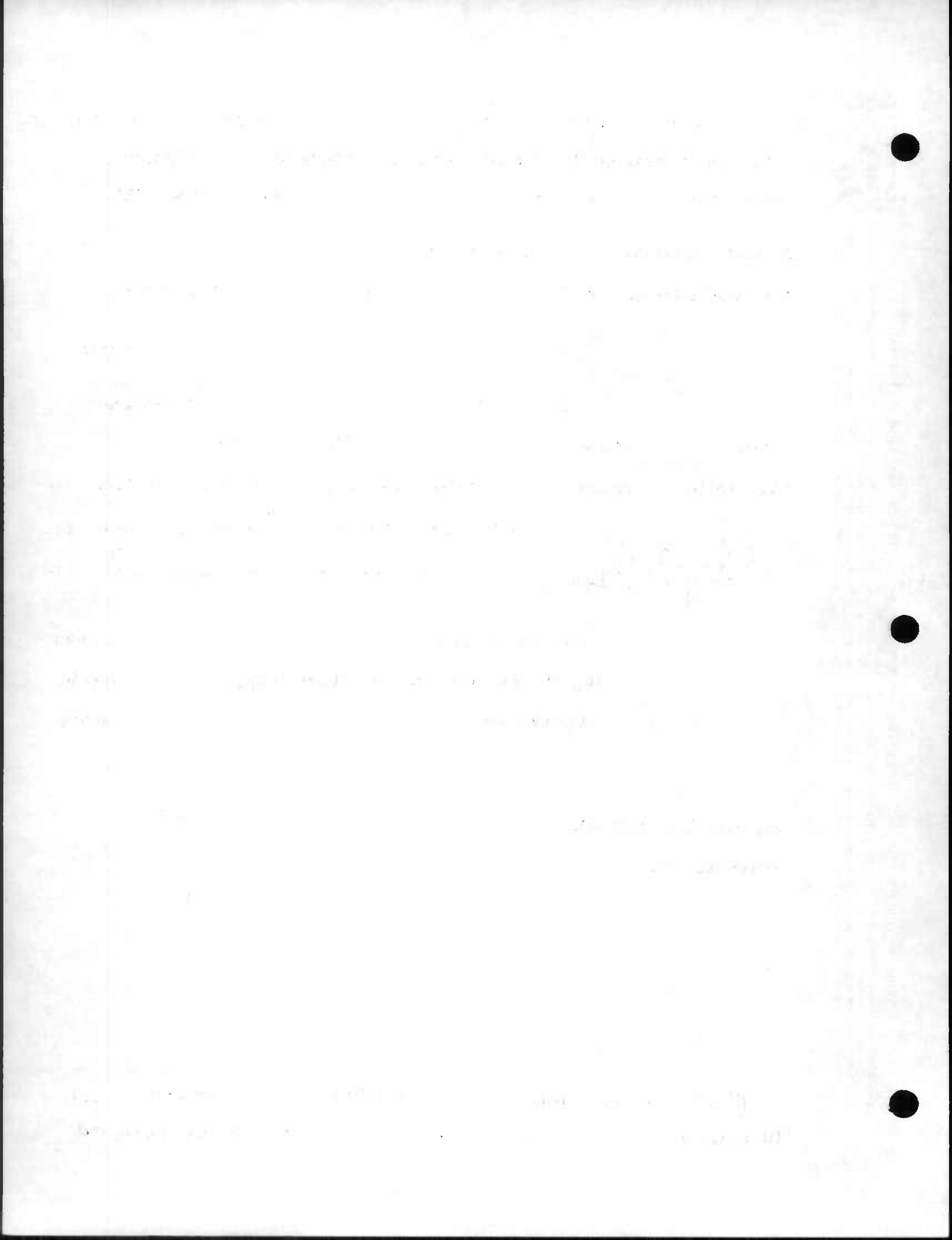
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04547

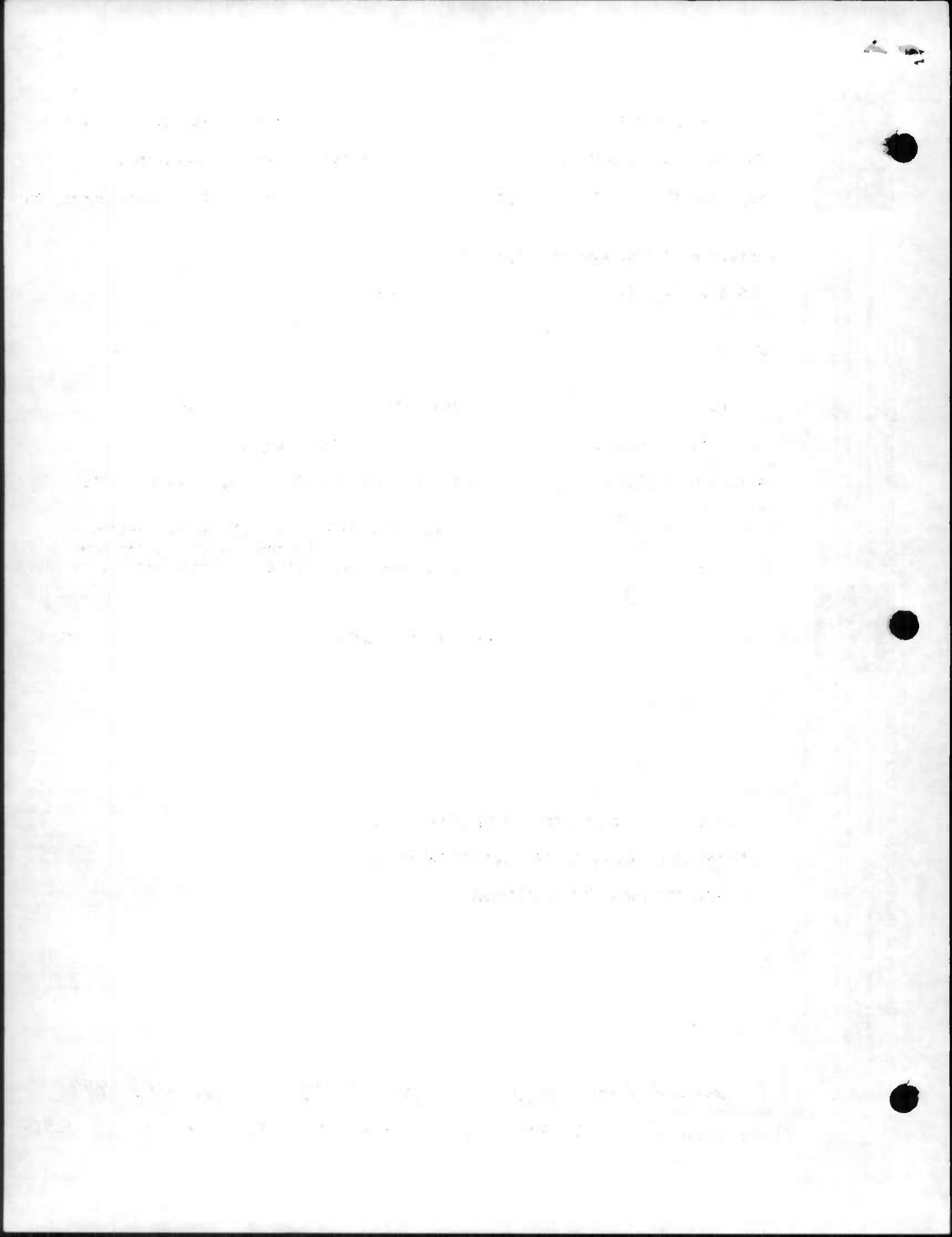
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen S. Markulis				2. Date of Death Month Day Year January 24, 1999				3. Time of Death 2:00 PM			
	4e. Facility Name (If not institution, give street and number) Fox Chase Nursing Home				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 579-05-4657		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.			
	8. Date of Birth (Month, Day, Year) Oct. 21, 1919		9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Hyattsville			
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 706 Sommerset Pl		10f. Zip Code 20783		10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector			
	16b. Kind of Business/Industry AT&T		17. Father's Name (First, Middle, Last) Spiro John Chaconas		18. Mother's Name (First, Middle, Maiden Surname) Elsie Ray Ticer		19a. Informant's Name/Relationship (Type, Print) Steven L. Markulis/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11516 Old Baltimore Pk, Beltsville, MD 20705			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Date Jan 28		20d. Location - City or Town, State Silver Spring, MD		21. Signature of Funeral Service Licensee Alan J. Danell			
	22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904		23a. Pert I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CARDIAC ARRYTHMIAS Due to (or as a consequence of): f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): Approximate Interval Between Onset and Death MINUTES		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Muhammad Ejaz M.D.			
	29c. License number Doo 52255		29d. Date signed (Month, Day, Year) Jan 27, 1999		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Muhammad Ejaz M.D. 8609 2nd Ave. #404 B Silver Spring, MD 20910		31. Date filed (Month, Day, Year) FEB 02 1999		32. Registrar's Signature Beverly B. Sparks			
	33. State Registrar											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04548

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>ELIZABETH S. MELENEY</b>						2. Date of Death Month Day Year <b>JAN. 30, 1999</b>		3. Time of Death <b>9:40 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>CARRAIGE HILL NURSING HOME</b>						4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>219-34-7950</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>94</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 26, 1904</b>		9. Birthplace (State or Foreign Country) <b>OHIO</b>	
Usual Residence of Decedent									
10a. State <b>MD.</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>BETHESDA</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>6703 PAWTUCKET RD.</b>				10f. Zip Code <b>20817</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TEACHER</b>			16b. Kind of Business/Industry <b>EDUCATION</b>		
17. Father's Name (First, Middle, Last) <b>HARLEY GIBBS SMITH</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>EDITH LADD</b>			
19a. Informant's Name/Relationship (Type, Print) <b>PETER L. MELENEY/SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6666 HILLANDALE RD., BETHESDA, MD. 20815</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		Date <b>2/3/99</b>		20c. Location - City or Town, State <b>RIVERDALE, MD.</b>			
21. Signature of Funeral Service Licensee <b>W.W. Chambers</b> M00091				22. Name and Address of Facility <b>CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): <b>b. DEMENTIA</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Approximate Interval Between Onset and Death									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Alpana Goswami MD</b>				29c. License number <b>D27660</b>		29d. Date signed (Month, Day, Year) <b>FEB. 1, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ALPANA GOSWAMI, M.D. 10901 CONNECTICUT AVE., KENSINGTON, MD.</b>									
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature <b>Beverly B. Sparks</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04549

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charline O. Miller

2. Date of Death  
Month Day Year  
February 1, 19993. Time of Death  
7:00 AM

4a. Facility Name (If not institution, give street and number)

Mariner Health - Kensington

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

Funeral  
Director5. Social Security Number  
496-03-10726. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
91 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
Nov. 1, 19079. Birthplace (State or Foreign  
Country)  
Missouri

Usual Residence of Decedent

10a. State  
MD10b. County  
Montgomery10c. City, Town or Location  
Kensington10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

4504 Westbrook Lane

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clerk Typist

16b. Kind of Business/Industry

Bernan Associates

17. Father's Name (First, Middle, Last)

Jesse O'Dell

18. Mother's Name (First, Middle, Maiden Surname)

Clara Pardue

19a. Informant's Name/Relationship (Type, Print)

Walter F. Miller (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4504 Westbrook Lane, Kensington, MD 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

2/4/99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral  
Home, Inc. 500 University Blvd. West  
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Alzheimer's disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

K. Graym

29c. License number

53284

29d. Date signed (Month, Day, Year)

2-1-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Koray 13975 Connecticut Ave Suite 308 Silver Spring MD 20906

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit






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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04550

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marjorie C. Mobberley</b>						2. Date of Death Month Day Year <b>January 31, 1999</b>		3. Time of Death <b>7:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Manor Care - Silver Spring</b>						4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>577-12-1434</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 3, 1919</b>		9. Birthplace (State or Foreign Country) <b>Washington, DC</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1608 Woodwell Road</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Assistant</b>			16b. Kind of Business/Industry <b>Construction</b>			
17. Father's Name (First, Middle, Last) <b>George Phillips</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie M. Tomlin</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Paula L. Himes (daughter)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1608 Woodwell Road, Silver Spring, MD 20906</b>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>2/1/99</b>		20c. Location - City or Town, State <b>Alexandria, VA</b>			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Intracerebral hemorrhage</b> Due to (or as a consequence of): b. <b>Hypertension</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death <b>1 month</b> <b>10 years</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b> <b>Coronary artery disease</b>										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number <b>D43237</b>		29d. Date signed (Month, Day, Year) <b>February 1, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Armstrong, M.D. 14201 Laurel Park Drive, Laurel, MD 20707</b>										
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

15



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04551

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE EDWIN MOELLER, SR.

2. Date of Death  
Month Day Year  
JANUARY 31, 19993. Time of Death  
9:20 PM

4a. Facility Name (If not institution, give street and number)

NATIONAL LUTHERAN HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

215-24-5654

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 11, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

9701 Veirs Drive

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Fire Chief

16b. Kind of Business/Industry

Baltimore City  
Fire Department

17. Father's Name (First, Middle, Last)

George H. Moeller

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Smith

19a. Informant's Name/Relationship (Type, Print)

Ruth Marie Wolpert, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13408 Rippling Brook Dr., Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery

Date

Feb 4, 1999

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home  
10 E. Deer Park Dr., Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Congestive Heart Failure

Due to (or as a consequence of):

b.

Strial Edema

Due to (or as a consequence of):

c.

Arteriosclerotic Coronary Artery Disease

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia, Diabetes Mellitus type II  
Hyperlipidemia, Alzheimer's Dementia  
Decubitus Ulcer, Osteoarthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D56618

29d. Date signed (Month, Day, Year)

February 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher M. Schemm, M.D., National Lutheran Home, ILP Clinic, Rockville, MD 20850

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04552

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Tomas C. Monje

2. Date of Death

January 31, 1999

3. Time of Death

4:30 am

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

212-80-0405

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

December 28, 1909

9. Birthplace (State or Foreign Country)

Philippines

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3900 Joliet Street

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lawn Care

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Agaton Monje

18. Mother's Name (First, Middle, Maiden Surname)

Margarita Cuaresma

19a. Informant's Name/Relationship (Type, Print)

Emely M. Orteza/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2800 Woodley Road N.W. #1 Washington, D.C. 20008

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

February 5, 1999

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

M00335

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557  
Bethesda, Maryland 20814-3501

Wisconsin Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS  
Due to (or as a consequence of):b. PNEUMONIA  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. END STAGE RENAL DISEASE  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-27660

29d. Date signed (Month, Day, Year)

2/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A-GURWANI MD- 10901 CONNETT AVE KENSINGTON, MD 20892

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





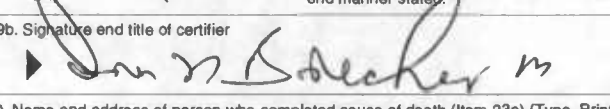
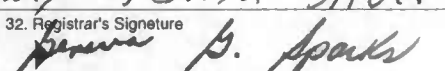
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04553

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bessie Moore</b>				2. Date of Death Month <b>Jan</b> Day <b>29</b> Year <b>1999</b>		3. Time of Death <b>1052</b>		
	4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>070-07-5982</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct 28, 1913</b>	9. Birthplace (State or Foreign Country) <b>New York</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>211 Russell Avenue, #621</b>				10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b></b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			16b. Kind of Business/Industry <b>Federal Government</b>		
17. Father's Name (First, Middle, Last) <b>Richard Gibson Bowers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rebecca Klein</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Walter Moore, Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13012 St. Charles Place, Rockville, MD 20853</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		Date <b>Feb. 1, 1999</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD 20877</b>					
23a. Pert I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. idioventricular rhythm</b> Due to (or as a consequence of): <b>b. subdural hematoma</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>chronic a-fib</b>				Approximate Interval Between Onset and Death <b>DME</b>					
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. <b>chronic a-fib</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Jan 28, 1999</b>		28b. Time of Injury <b>9:25 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Patient fell</b>	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Assisted Living Facility</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>211 Russell Ave, Gaithersburg, MD</b>							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number <b>D00428</b>		29d. Date signed (Month, Day, Year) <b>Jan 29, 1999</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR M BRECHER, MD, DME Silver Spring MD 20902</b>									
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04554

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Price Martin

2. Date of Death

Month Day Year  
Feb 3, 1999

3. Time of Death

1:45 pm

4a. Facility Name (If not institution, give street and number)

Long View Nursing Home

4b. City, Town, or Location of Death

Manchester

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

216-03-5391

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 14, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Hampstead

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Clearview Road

10f. Zip Code

21074

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Albert Irvin Martin

18. Mother's Name (First, Middle, Maiden Surname)

Lula M. Price

19. Informant's Name/Relationship (Type, Print)

Louise H. Cole, niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16648 Trenton Rd, Upperco, Md 21155

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Forest Baptist Cemetery

Date

2/6

20c. Location - City or Town, State

Upperco, MD

21. Signature of Funeral Service Licensee

Stevens W Eline

22. Name and Address of Facility

Eline Funeral Home

934 South Main St, Hampstead, Md 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. *Alzheimer's Disease*  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Steven S. S. 2111 Hammer Rd. Forest Hill MD 21074

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04555

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM JAMES MARSHALL</b>				2. Date of Death Month Day Year <b>Jan. 30 1999</b>		3. Time of Death <b>9:30 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Talbot Hospice House</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>218-07-1315 A</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 11, 1920</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Talbot</b>		10c. City, Town or Location <b>Wittman</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>8727 Sewell Pt. Rd.</b>				10f. Zip Code <b>21676</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waterman</b>			16b. Kind of Business/Industry <b>Seafood</b>	
17. Father's Name (First, Middle, Last) <b>Percy Ruben Marshall</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edith Pollard</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Marie Meta Pyle Marshall Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 193 Wittman, Maryland 21676</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Olivet Cemetery Feb. 2, 1999</b>			Data		20c. Location - City or Town, State <b>St. Michaels, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Harrison E. Leonard</i>				22. Name and Address of Facility <b>Harrison E. Leonard Funeral Home 312 S. Talbot St. Michaels, Maryland 21663</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Transitional Cell Carcinoma</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>20 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice House</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>House</b>
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Mary S. De Shields, M.D.</i>		29c. License number <b>D47232</b>		29d. Date signed (Month, Day, Year) <b>2/1/98</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mary S. De Shields, M.D. 509 Idlewild Ave. Easton, Maryland 21601</b>								
31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>		32. Registrar's Signature <i>B. Apala</i>						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28c show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04556

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELSIE E. NICHOLSON

2. Date of Death

Month January Day 28, Year 1999

3. Time of Death

2:15 P.M.

4a. Facility Name (If not institution, give street and number)

903 Cedar Street

4b. City, Town, or Location of Death

Pocomoke City

4c. County of Death

Worcester

5. Social Security Number

218-20-5092

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) November 6, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

903 Cedar Street

10f. Zip Code

21851

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

H. Glenwood Evans

18. Mother's Name (First, Middle, Maiden Surname)

Mary Adelaide Evans

19a. Informant's Name/Relationship (Type, Print)

Nancy A. Nicholson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

903 Cedar Street- Pocomoke City, MD 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunnyridge Memorial Park

Date

2/1/99

20c. Location - City or Town, State

Crisfield, MD

21. Signature of Funeral Service Licensee

Robert H. Bradshaw, Jr.

22. Name and Address of Facility

Bradshaw & Sons Funeral Home  
306 W. Main St.- Crisfield, MD 21817

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OF THE LUNG

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. G. Santiano

29c. License number

202556

29d. Date signed (Month, Day, Year)

01-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. G. Santiano, M.D. - 100 8th Street - Pocomoke City, MD 21851

State  
Registrar

31. Date filed (Month, Day, Year)

FEB - 1 1999

32. Registrar's Signature

J. G. Santiano

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





99 04557

DHHH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04558  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Randolph G. Outen Sr.</b>				2. Date of Death Month Day Year <b>January 30, 1999</b>		3. Time of Death <b>1237</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>217-28-4024</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>10-1-33</b>		9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1013 S. Delano Ave</b>				10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>U.S</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>6 yrs</b>				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>EDUCATOR</b>		16b. Kind of Business/Industry <b>Superintendent of Schools Harrisburg, PA</b>		
17. Father's Name (First, Middle, Last) <b>Alonso Outen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Mae Fountaine</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Sylvia Outen / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1013 S. Delano Ave. Salisbury, MD 21801</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springhill Memory Garden</b>		20c. Date <b>2-3-99</b>		20d. Location - City or Town, State <b>Salisbury, MD</b>		
21. Signature of Funeral Service Licensee <b>Art E. Walz</b>				22. Name and Address of Facility <b>Anthony E. Ward Funeral Home 30639 Hampton Ave. Princess Anne, MD 21853</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Ruptured Abdominal Aortic Aneurysm</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>1 1/2 hrs.</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b> <b>Hypertension</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>David C. Kerrigan, MD</b>		29c. License number <b>D44688</b>		29d. Date signed (Month, Day, Year) <b>12/30/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David C. Kerrigan, MD Salisbury, MD</b>								
31. Date filed (Month, Day, Year) <b>FEB - 4 1999</b>		32. Registrar's Signature <b>Beverly B. Sparks</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Randolph Outen

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

04559

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Vincent William Panciera</b>				2. Date of Death Month Day Year <b>February 1, 1999</b>		3. Time of Death <b>10:40 A.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>111 Waterland Court</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>126-16-8225</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 8, 1928</b>	
9. Birthplace (State or Foreign Country) <b>New York</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>111 Waterland Court</b>				10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>1946-</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+) 5+</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nuclear Engineer</b>		16b. Kind of Business/Industry <b>Nuclear Regulatory Commission</b>	
17. Father's Name (First, Middle, Last) <b>Joseph Panciera</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eugenia Gandolfi</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Margaret C. Panciera (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>111 Waterland Court, Frederick, Maryland 21702</b>			
20a. Method of Disposition <b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>2-2-99</b>		20c. Location - City or Town, State <b>Beltsville, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. metastatic carcinoma of the palate</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>						Approximate Interval Between Onset and Death <b>3 m.</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>myelodysplastic syndrome</b> <b>Aortic stenosis</b>						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown	
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No					
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> Other (Specify)					
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D 48184</b>		29d. Date signed (Month, Day, Year) <b>Feb. 1, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Elhamy Eskander MD 501 W 7th Street Frederick MD 21701</b>							
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04560

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THERESA R. PARRECO

2. Date of Death  
Month Day Year

JANUARY 29, 1999

3. Time of Death

8:15 PM

4a. Facility Name (If not institution, give street and number)

SPRINGBROOK NURSING & REHABILITATION CENTER

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

578-62-8520

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APRIL 17, 1903

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

ADELPHI

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2002 DANNA DRIVE

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

RALPH CORRALO

18. Mother's Name (First, Middle, Maiden Surname)

MARIE GISMONDI

19a. Informant's Name/Relationship (Type, Print)

HANS P. GATES / SON-IN-LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2002 DANNA DRIVE ADELPHI MARYLAND 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

2/1/99

20c. Location - City or Town, State

BRENTWOOD MARYLAND

21. Signature of Funeral Service Licensee

*James O. Schmitt*

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.  
11800 NEW HAMPSHIRE AVE. SILVER SPRING MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dehydration

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 mo.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Swallowing Dysfunction

Due to (or as a consequence of):

11 mos

c. Cerebrovascular Accident

Due to (or as a consequence of):

11 mos.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intermittent Intestinal Obstruction, Dementia,

Atrial Fibrillation, Hypertension, Gout,

Advanced Liver Disease, Temporal Arteritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Stuart J. Turkewitz M.D.*

29c. License number

D31001

29d. Date signed (Month, Day, Year)

2/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart J. Turkewitz, M.D.

7500 Greenway Cntr. Dr. #430  
Greenbelt, MD. 20770

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

*Benita B. Sparks*

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04561

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charlotte C. Peterson				2. Date of Death Month Day Year January 29, 1999				3. Time of Death 7:35 PM		
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 578-12-6172	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	8. Date of Birth (Month, Day, Year) March 1, 1919	9. Birthplace (State or Foreign Country) Virginia						
	Usual Residence of Decedent										
10e. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 13917 Vista Drive				10f. Zip Code 20853		10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Associate			16b. Kind of Business/Industry Conveyor Belt Association				
17. Father's Name (First, Middle, Last) Paul K. Cummins				18. Mother's Name (First, Middle, Maiden Surname) Ruth Fowler							
19a. Informant's Name/Relationship (Type, Print) Linda C. Peterson (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13917 Vista Drive, Rockville, Maryland 20853							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 2-1-99		20c. Location - City or Town, State Beltsville, Maryland					
21. Signature of Funeral Service Licensee Carol A. Dehm				22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 4 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier A. Rajvanshi, M.D.				29c. License number D37891		29d. Date signed (Month, Day, Year) January 30, 1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rajvanshi, M.D., 121 Congressional Lane, #409, Rockville, Maryland 20852											
31. Date filed (Month, Day, Year) FEB 02 1999		32. Registrar's Signature B. Sparks									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04562

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Sheldon Philbrook II

2. Date of Death  
Month  
January

Day

27

Year

1999

3. Time of Death

5:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

262-40-7832

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 7 1930

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Cheverly

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2900 Mercy Lane

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

English Language School

17. Father's Name (First, Middle, Last)

Charles S. Philbrook, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Carmen Philbrook - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10229 Quito Street Cooper City, FL 33026

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Balt.-Wash. Crematory

Date

2/1/99

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

Joseph M. Peters

22. Name and Address of Facility

Joseph Gawler's Sons

5130 Wisconsin Ave. N.W. Washington, D. C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory Failure Dementia

Multiple Decubiti Pneumonia

Insulin Dependent Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles Sheldon Philbrook II

29c. License number

D01852

29d. Date signed (Month, Day, Year)

January 27 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL A. DEVORE, MD 4203 QUEENSBURY Rd Hyattsville MD 20781

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04563

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

GLADYS B. PRICE

2. Date of Death

Month Day Year  
FEB 4 1999

3. Time of Death

0426 AM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL @ EASTON

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

220-16-9424

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 10, 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

702 S. WASHINGTON ST.

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

BERNHARD A. BLOCK

18. Mother's Name (First, Middle, Maiden Surname)

GLADYS SUTER

19a. Informant's Name/Relationship (Type, Print)

EUGENE H. PRICE/ HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 495, EASTON, MD 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SPRING HILL CEMETERY

Date

2-8-99

20c. Location - City or Town, State

EASTON, MD 21601

21. Signature of Funeral Service Licensee

*M. E. Newman* MD CFSP

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A.  
200 S. HARRISON ST., EASTON, MD 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Hypotension  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Hypoxic Encephalopathy  
Due to (or as a consequence of):

c. Probable Brain Stem CVA Bell's palsy.

4 days

d. coronary artery disease S/P CABG.

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Hypertension  
chronic renal failure*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*SOAR*

29c. License number

D46020

29d. Date signed (Month, Day, Year)

2/4/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SYED I. ALI, M.D., 506 IDLEWILD AVENUE, EASTON, MD 21601

31. Date filed (Month, Day, Year)

FEB 06 1999

32. Registrar's Signature

*Benjamin B. Sparks*State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

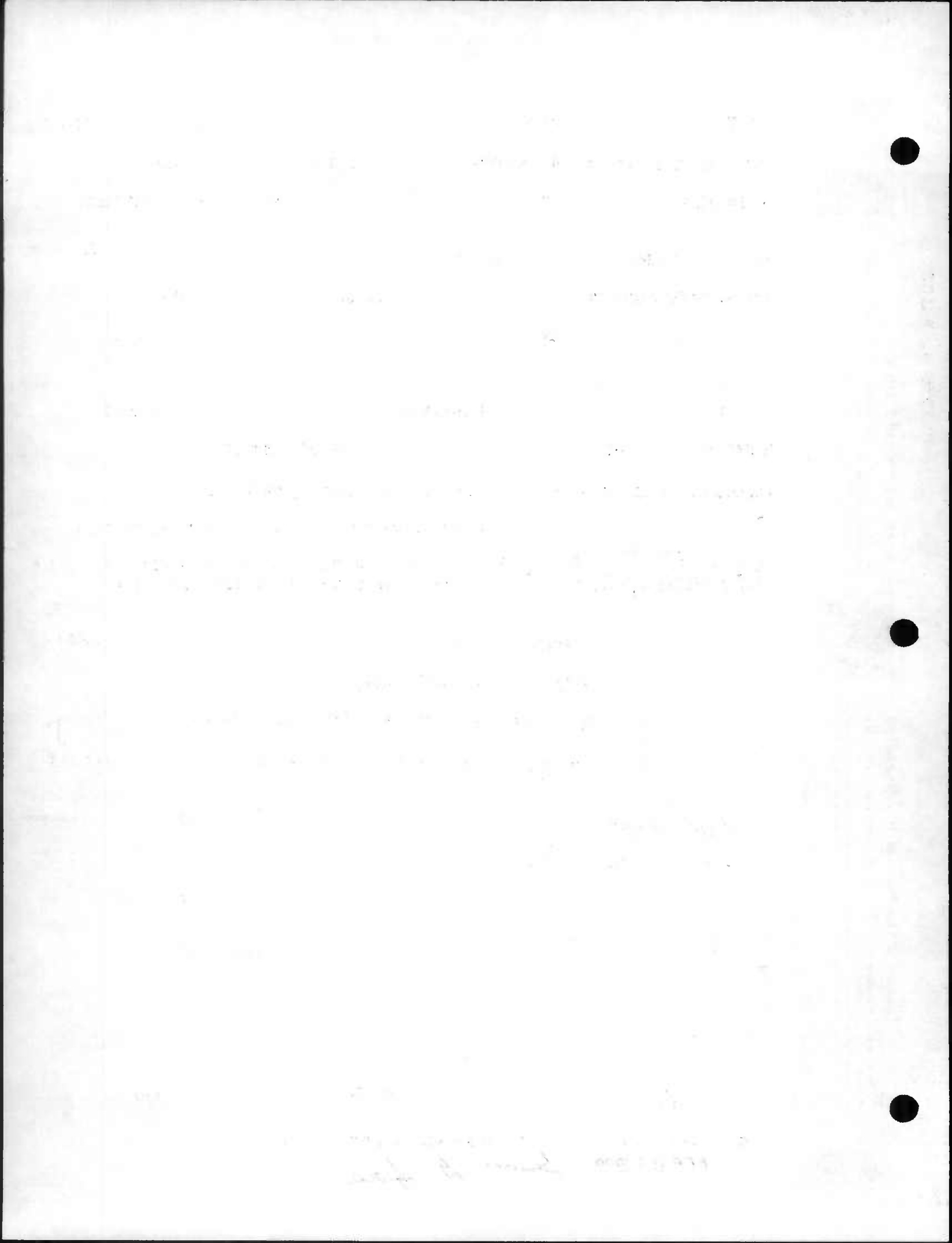
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04564

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Ann Redish

2. Date of Death

January 26, 1999

3. Time of Death

9:07 PM

4a. Facility Name (If not Institution, give street and number)

Shady Grove Adventist Nursing &amp; Rehabilitation Rockville

4b. City, Town, or Location of Death

4c. County of Death

Montgomery

5. Social Security Number

266-42-6955

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 6, 1933

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

910 College Parkway

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Computer Programmer

16b. Kind of Business/Industry

United States  
Government

17. Father's Name (First, Middle, Last)

Wilbur Wallace Redish

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Verna Bowen

19a. Informant's Name/Relationship (Type, Print) Brother/

Wilbur Wallace Redish, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13451 Friar Street, Van Nuys, California 91401-2408

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Middletown Cemetery

Date

May 1999

20c. Location - City or Town, State

Richmond, New Hampshire

21. Signature of Funeral Service Licensee

M00846

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Avenue, Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic Renal Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 Years

b. Hypertension

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Jonathan S. Plotsky, M.D.

29c. License number

D38589

29d. Date signed (Month, Day, Year)

January 28, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jonathan S. Plotsky, M.D., 15225 Shady Grove Road #102, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 37 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04565

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

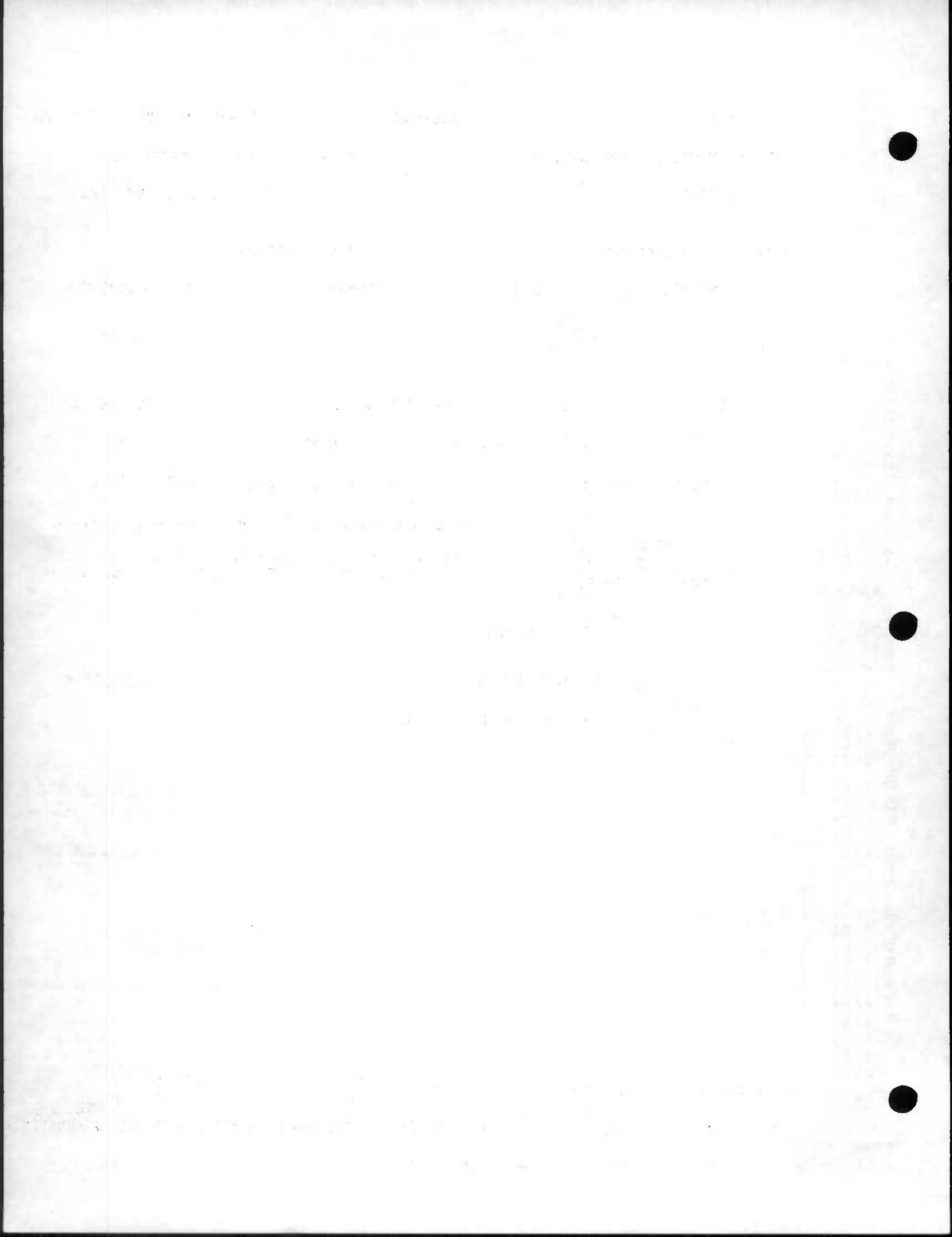
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>EVA F. RICHMOND</b>		2. Date of Death Month <b>JANUARY</b> Day <b>29</b> Year <b>1999</b>		3. Time of Death <b>7:30 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>11550 STEWART LANE, APT. # 304</b>		4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>225-32-3069</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>NOV. 12, 1927</b>		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>			
Usual Residence of Decedent					
10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>SILVER SPRING</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>11550 STEWART LANE, APT. # 304</b>		10f. Zip Code <b>20904</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CREDIT MANAGER</b>		16b. Kind of Business/Industry <b>CHOICE HOTELS</b>	
17. Father's Name (First, Middle, Last) <b>WILLIAM ELLIS FUGATE</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>BIRDIE GRABLE</b>			
19a. Informant's Name/Relationship (Type, Print) <b>ROBERT L. RICHMOND/ SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5200 LINCOLN DRIVE, EDINA, MINNESOTA 55436</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GEORGE WASHINGTON CEM.</b>		20c. Location - City or Town, State <b>2/3/99 ADELPHI, MARYLAND</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>HINES- RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MARYLAND 20904</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Liver Failure</b> Due to (or as a consequence of): <b>Liver Metastasis</b> Due to (or as a consequence of): <b>Gastric &amp; Colon Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>1 year</b>					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D17368</b>		29d. Date signed (Month, Day, Year) <b>02/01/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STANLEY A. SCHWARTZ, M.D., 2101 MEDICAL PARK DRIVE, #210 SILVER SPRING MARYLAND 20902-4000</b>					
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04566

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Preston William Riley</b>		2. Date of Death Month: <b>January</b> Day: <b>30</b> Year: <b>1999</b>		3. Time of Death <b>3:25 AM</b>														
	4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hospital</b>		4b. City, Town, or Location of Death <b>Olney</b>		4c. County of Death <b>Montgomery</b>														
Funeral Director	5. Social Security Number <b>577 03 2299</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.														
	8. Date of Birth (Month, Day, Year) <b>July 2 1913</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>																
Usual Residence of Decedent																			
10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Columbia</b>															
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
10e. Street and Number <b>5570 Vantage Point Rd. #4</b>			10f. Zip Code <b>21044</b>		10g. Citizen of What Country? <b>United States</b>														
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:															
14. Race - American Indian, Black, White, etc. <b>White</b>		Specify:																	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (14 or 5+) <b>0</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Barber</b>		16b. Kind of Business/Industry <b>Hair Care</b>														
17. Father's Name (First, Middle, Last) <b>Bennett Dolphus Riley</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ida Derzine</b>																
19a. Informant's Name/Relationship (Type, Print) <b>John Riley/ SON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7122 Rivers View Ct. Columbia Md 21044</b>																
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Washington Univ. Med. Ctr.</b>		20c. Location - City or Town, State <b>1/30/99 Washington DC</b>															
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <b>Columbia Mortuary Services PO Box 58007 Washington DC 20037</b>																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>PNEUMONIA</b></td> <td>Due to (or as a consequence of):</td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>DAYS</b> </td> </tr> <tr> <td>b.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>PNEUMONIA</b>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>DAYS</b>	b.		Due to (or as a consequence of):	c.		Due to (or as a consequence of):	d.		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>PNEUMONIA</b>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>DAYS</b>															
	b.		Due to (or as a consequence of):																
	c.		Due to (or as a consequence of):																
	d.		Due to (or as a consequence of):																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown															
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M															
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred															
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>80051865</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 30, 1999</b>															
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>DEEPAK GUPTA, MD 3905 NATIONAL AVE SUITE 220 FORT MONROE, MD 20866</b>																			
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature <i>[Signature]</i>																	

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04567

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY BERNARD ROBINSON</b>				2. Date of Death Month Day Year <b>01.30.1999</b>		3. Time of Death <b>2:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BEDFORD COURT NURSING HOME</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>578.01.2976</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>01.15.1914</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>SILVER SPRING</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3700 INTERNATIONAL DRIVE</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PHARMACIST</b>			16b. Kind of Business/Industry <b>PHARMACY</b>	
17. Father's Name (First, Middle, Last) <b>MORRIS ROBINSON</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>HATTIE COHEN</b>			
19a. Informant's Name/Relationship (Type, Print) <b>IRENE Z. ROBINSON/WIFE</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15107 INTERLACHEN DR #517, SILVER SPRING, MD 20906</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING DAVID MEMORIAL GDNS</b>			20c. Location - City or Town, State <b>02.1.99 FALLS CHURCH, VIRGINIA</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Aspiration Pneumonia</b> Due to (or as a consequence of): <b>b. Parkinson Disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Organic brain syndrome</b> <b>Chronic Anemia</b>								Approximate Interval Between Onset and Death <b>3 wks</b> <b>10 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Organic brain syndrome</b> <b>Chronic Anemia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  M.D.					29c. License number <b>D 18726</b>		29d. Date signed (Month, Day, Year) <b>January 30, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ARTHUR SCHUENGOLD, M.D. 18111 Prince Philip Dr, OLNEY, MD 20832</b>								
31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>			32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

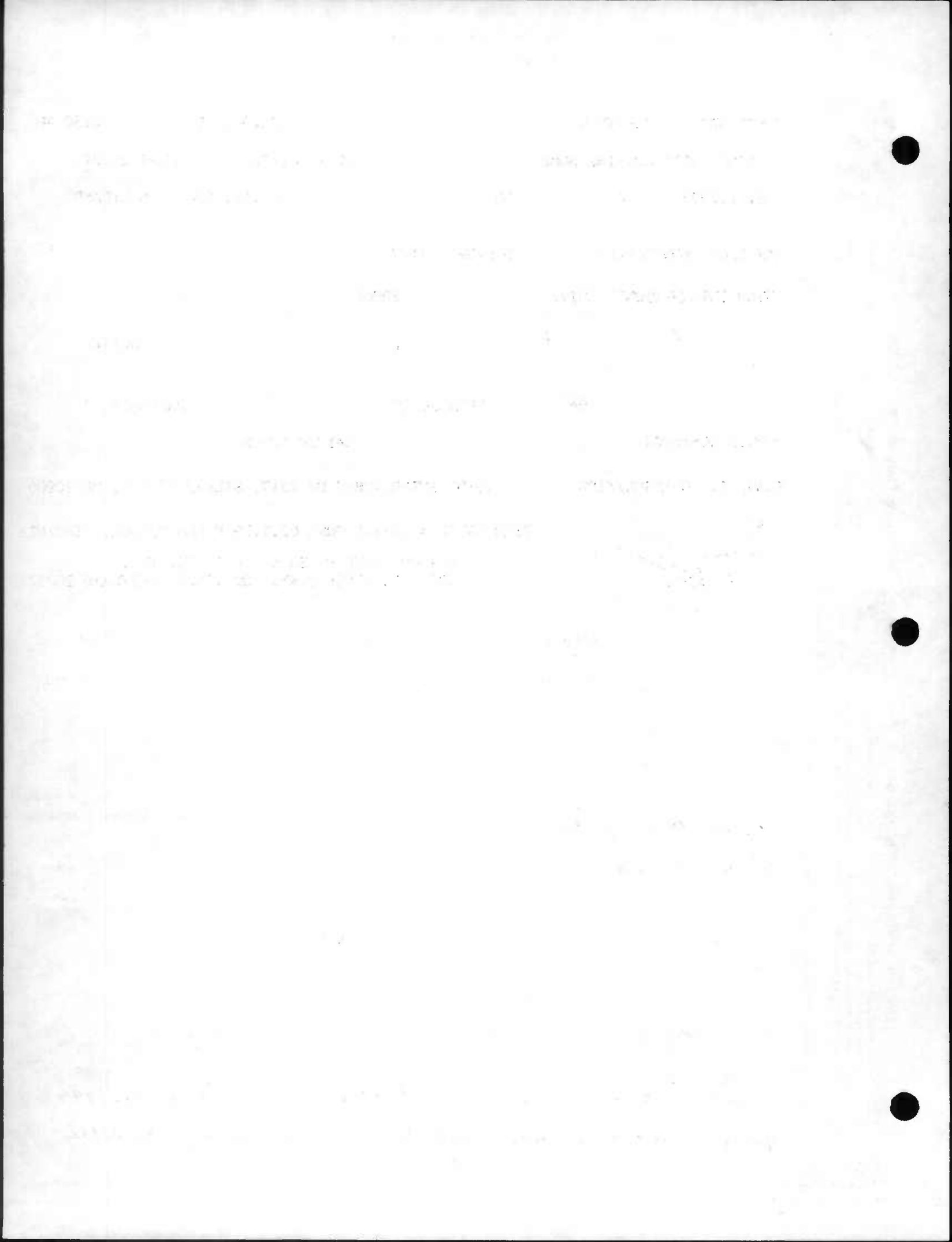
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04568

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN FRANKLIN ROSE, SR.

2. Date of Death  
Month Day Year  
January 27 19993. Time of Death  
7:35 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577 42 1158

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 6, 1933

9. Birthplace (State or Foreign Country)

Nelson Cty, VA.

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1401 Blair Mill Road, #915

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Stockbroker

16b. Kind of Business/Industry

Securities

17. Father's Name (First, Middle, Last)

Frank Boyd Rose

18. Mother's Name (First, Middle, Maiden Surname)

Mary Susan Blair

19a. Informant's Name/Relationship (Type, Print)

Alpha G. Rose/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1401 Blair Mill Rd, #915, Silver Spring, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

2/1/99

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Lynne McGuire

22. Name and Address of Facility

McGuire Funeral Service, Inc.  
7400 Georgia Avenue, N.W. Wash., D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. HYPERTENSION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

BPH

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of causa of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Lynne McGuire

29c. License number

D34472

29d. Date signed (Month, Day, Year)

1-27-99

30. Name and address of person who completed causa of death (Item 29a) (Type, Print)

Lynne Diggs, M.D. Holy Cross Hospital, 1500 Forest Glen Road, Silver Spring, MD 20910

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

Lynne B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04569

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LENA ROSENSKY</b>				2. Date of Death Month Day Year <b>February 2, 1999</b>		3. Time of Death <b>6:10 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>579-58-8571</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 15, 1912</b>	9. Birthplace (State or Foreign Country) <b>Poland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1801 East Jefferson Street</b>				10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Years</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Morris Rosensky</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sonya Abramson</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Martin Rosensky, Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15012 Redgate Drive, Silver Spring, Maryland 20905</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Shaare Tefila Congregation Section of Mount Lebanon Cemetery</b>			Date <b>2/4/1999</b>		20c. Location - City or Town, State <b>Adelphi, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  b. <b>ARTERIOSCLEROTIC HEART DISEASE</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  <b>27 DAYS</b>  <b>8 YEARS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D09946</b>		29d. Date signed (Month, Day, Year) <b>February 2, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Henry Roth, MD., 1801 East Jefferson Street, Rockville, Maryland 20852</b>								
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





99 04570

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BENJAMIN W. RUDD</b>				2. DATE OF DEATH MONTH DAY YEAR <b>01.30.1999</b>		3. TIME OF DEATH <b>10:30 p m</b>	
4. SOCIAL SECURITY NUMBER <b>034.16.0162</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08.28.1906</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MASS.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>HEALTHSOUTH REHAB. OF MARYLAND</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>	
10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1121 UNIVERSITY BLVD. WEST #1004</b>	
10f. ZIP CODE <b>20902</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ATTORNEY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>LAW</b>	
17. FATHER'S NAME (First, Middle, Last) <b>"UNKNOWN" RUDD</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MOLLIE BOOKMAN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>RITA RUDD/WIFE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1121 UNIVERSITY BLVD W #1004, SILVER SPRING, MD 20902</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING DAVID MEMORIAL GDNS 2.1.99 FALLS CHURCH, VIRGINIA</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral Hemorrhage</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>History of Abdominal Aortic Aneurysm repair</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Wilkinson J. Ninala</b>				29c. LICENSE NUMBER <b>D 45285</b>		29d. DATE SIGNED (Month, Day, Year) <b>January 31, 1999</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>W.J. Ninala, 344 University Blvd, #113, Silver Spring, Md 20901</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 01 1999</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04571

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Theodore Howard Runyan

2. Date of Death

Month Day Year  
Jan 26 1999

3. Time of Death

03:45pm

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

538-03-6625

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 13, 1917

9. Birthplace (State or Foreign Country)

Seattle, Wa.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

617 Lincoln Street

10f. Zip Code

20850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1942 to 4813. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Maryland State Police Officer

16b. Kind of Business/Industry

Maryland State Police

17. Father's Name (First, Middle, Last)

Unavailable

18. Mother's Name (First, Middle, Maiden Surname)

Unavailable

19a. Informant's Name/Relationship (Type, Print)

Wife - Hilda Isabel Runyan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

617 Lincoln St., Rockville, Md. 20850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

Jan. 28, 1999, Alex. Va.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

2222 Wisc. Ave., N.W., Wash. D. C. 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Acute Renal Failure  
Due to (or as a consequence of):b. Volume depletion  
Due to (or as a consequence of):c. Bilateral pneumonia  
Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

48°

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, tectory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41931

29d. Date signed (Month, Day, Year)

Jan 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R Shuman MD 2309 Shorefield Rd Wheaton, MD 20902

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04572

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vera Ellen Ritenour

2. Date of Death

February 1, 1999

3. Time of Death

11:15 AM

4a. Facility Name (If not institution, give street and number)

Gilcrest Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

578-12-1245

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 1, 1920

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9830 Michael's Way

10f. Zip Code

21042

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Comptroller

16b. Kind of Business/Industry

Commerce Dept.

17. Father's Name (First, Middle, Last)

Andrew Fred Cranford, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Vera Nevada Sapp

19a. Informant's Name/Relationship (Type, Print)

Andrew F. Cranford, Jr.-Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9830 Michaels Way, Ellicott City, MD. 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Washington National Cem. 2-6-99 Suitland, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Mark G. Brohawn M00053

22. Name and Address of Facility

Huntt Funeral Home, Inc.  
P. O. Box 156, Waldorf, MD 20604-0156

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

11 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Anthony Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

February 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W A Riley GBMC 6701 N. Charles St. Balto. Md 21204

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

James B. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Vera Ritenour February 1, 1999 11:5A  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04573

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BERNICE A. RITCHIE

2. Date of Death

FEBRUARY 2, 1999

3. Time of Death

7:35 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

9114 Ballard Lane

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

287-18-7788

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV 20 1918

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

9114 Ballard Lane

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Public Education

17. Father's Name (First, Middle, Last)

Roy Balsley

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Callahan Balsley

19a. Informant's Name/Relationship (Type, Print)

Melissa A. Ritchie (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9114 Ballard Lane Clinton, MD 20735

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

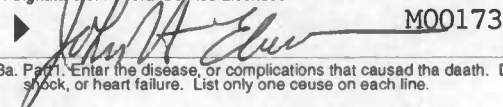
Metropolitan Crematory 2-3-99

Date

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

 MO0173

22. Name and Address of Facility

J.H. Eberwein Mortuary

4433 White Pls La White Pls., MD 20695

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CARCINOMA OF LUNG

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

MONTHS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D12906

29d. Date signed (Month, Day, Year)

2/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Louis Kaufman M.D. 8926 Woodyard Road #602 Clinton, MD 20735

31. Data filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04574

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Myrtle Rebecca Rice

2. Date of Death

Month Day Year  
Jan 30, 1999

3. Time of Death

1:15 pm

4a. Facility Name (If not institution, give street and number)

Long View Nursing Home

4b. City, Town, or Location of Death

Manchester

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

212-05-1387

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 23, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7904 Ruxway Road

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Asa Tydings

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Linthicum

19a. Informant's Name/Relationship (Type, Print)

C. Thomas Rice, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15408 Parrish Rd, Upperco, MD 21155

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Druid Ridge Cemetery

Date

2/2

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

► *Steven W. Eline*

22. Name and Address of Facility

Eline Funeral Home

934 South Main St, Hampstead, Md 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

*Arteriosclerotic Disease*

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death*Yrs.*Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

► *Steven W. Eline*

29c. License number

*D33165*

29d. Date signed (Month, Day, Year)

*2/1/99*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Steven W. Eline 2111 Hanover Pike Hampstead and 2 copies*

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

*Steven W. Eline*State  
Registrar

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04575

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Violet Mae Schiavello

2. Date of Death

January 27, 1999

3. Time of Death

10:30 PM

4a. Facility Name (If not institution, give street and number)

4311 Fernhill Road

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

048-14-6658

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 9, 1926

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4311 Fernhill Road

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Food Service

16b. Kind of Business/Industry

Montgomery County  
Schools

17. Father's Name (First, Middle, Last)

John Anderson

18. Mother's Name (First, Middle, Maiden Summa)

Emma Houser

19a. Informant's Name/Relationship (Type, Print)

Frank Schiavello (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4311 Fernhill Road Silver Spring, Maryland 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery 01/30/99 Silver Spring, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Anchew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. EmpysemA

Due to (or as a consequence of):

3 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Garrett Reilly, M.D.

29c. License number

D39190

29d. Date signed (Month, Day, Year)

January 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Garrett Reilly, M.D. 3418 Olandwood Court #111 Olney, MD 20832

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

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Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04576

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ourania Schizoupoulou

2. Date of Death  
Month Day Year

FEBRUARY 4, 1999

3. Time of Death

11:32 PM

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

7501 Democracy Boulevard Apt. #321

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

213-15-6334

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

93

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth  
(Month, Day, Year)

Dec. 6, 1905

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7501 Democracy Boulevard Apt. #321

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Nikolaos Davakis

18. Mother's Name (First, Middle, Maiden Surname)

Panayiota Davakis

19a. Informant's Name/Relationship (Type, Print)

Katherine Johnson (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7501 Democracy Boulevard, Apt. 321, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Sotiras Cemetery

Date

2/6/99

20c. Location - City or Town, State

Kitta Lakonias,

Greece

21. Signature of Funeral Service Licensee

William L. B. J.

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. HYPERTENSION

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Many Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. ATRIAL FIBRILLATION

Due to (or as a consequence of):

1 year

c. DIABETES MELLITUS

Due to (or as a consequence of):

1 year

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Osteoporosis

Arthritis

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. Lee MD

29c. License number

D44513

29d. Date signed (Month, Day, Year)

February 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANG-KYUNE LEE, MD 15201 SHADY GROVE RD #202 ROCKVILLE, MD 20850

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and is  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04577

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Roger M. Smith

2. Date of Death

Jan 31 1999

3. Time of Death

0525

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-50-5502

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 5, 1939

Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1203 Clement Place

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Physicist

16b. Kind of Business/Industry

US Department of Navy

17. Father's Name (First, Middle, Last)

Ralph G. Smith

18. Mother's Name (First, Middle, Maiden Surname)

Barbara Paton

19a. Informant's Name/Relationship (Type, Print)

Mary Helen Smith (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1203 Clement Place, Silver Spring, Maryland 20910

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

2-1-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Dehm

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

D

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jan M. B. ...

29c. License number

D00428

29d. Date signed (Month, Day, Year)

Jan 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRA N BRETHER, MD

2101 Medical Park Dr Silver Spring MD 20902

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

25





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 04578**  
**Certificate of Death**

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Hilda Spurgeon</b>				2. Date of Death Month <b>January</b> Day <b>30</b> Year <b>1999</b>				3. Time of Death <b>1:50pm</b>																																
	4a. Facility Name (If not institution, give street and number) <b>8107 Eastern Ave #412D</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>				4c. County of Death <b>Montgomery</b>																																
<b>Funeral Director</b>	5. Social Security Number <b>089-05-8072</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.																																
	8. Date of Birth (Month, Day, Year) <b>March 31, 1908</b>		9. Birthplace (State or Foreign Country) <b>England</b>																																						
Usual Residence of Decedent																																									
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																	
10e. Street and Number <b>8107 Eastern Ave #412D</b>				10f. Zip Code <b>20910</b>				10g. Citizen of What Country? <b>USA</b>																																	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>																																	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Person</b>				16b. Kind of Business/Industry <b>retail</b>																																	
17. Father's Name (First, Middle, Last) <b>Bernard Spurgeon</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Rachel L. Alterman</b>																																			
19a. Informant's Name/Relationship (Type, Print) <b>Dorothy Rosenberg-Niece</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1900 Lytonsville Rd #207 Silver Spring, MD 20910</b>																																			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King David Mem. Gardens</b>		Date <b>2/2/99</b>		20c. Location - City or Town, State <b>Falls Church, VA</b>																																	
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville, MD 20852</b>																																			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																									
<table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;"> <b>Immediate Cause (Final disease or condition resulting in death)</b>   <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</b> </td> <td style="width:60%; vertical-align: top;"> <table border="0"> <tr> <td style="width:5%;">a.</td> <td style="width:75%;"><b>CONGESTIVE HEART FAILURE</b></td> <td style="width:20%; text-align: center;">Due to (or as a consequence of):</td> <td style="width:10%; text-align: center;"><b>1 YEAR</b></td> </tr> <tr> <td>b.</td> <td><b>HYPERTENSION</b></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td style="text-align: center;"><b>5 YRS</b></td> </tr> <tr> <td>c.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> </table> </td> </tr> </table>											<b>Immediate Cause (Final disease or condition resulting in death)</b>  <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</b>	<table border="0"> <tr> <td style="width:5%;">a.</td> <td style="width:75%;"><b>CONGESTIVE HEART FAILURE</b></td> <td style="width:20%; text-align: center;">Due to (or as a consequence of):</td> <td style="width:10%; text-align: center;"><b>1 YEAR</b></td> </tr> <tr> <td>b.</td> <td><b>HYPERTENSION</b></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td style="text-align: center;"><b>5 YRS</b></td> </tr> <tr> <td>c.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> </table>	a.	<b>CONGESTIVE HEART FAILURE</b>	Due to (or as a consequence of):	<b>1 YEAR</b>	b.	<b>HYPERTENSION</b>	Due to (or as a consequence of):	<b>5 YRS</b>	c.		Due to (or as a consequence of):		d.		Due to (or as a consequence of):														
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<b>29a. Certifier (Check only one)</b> <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																									
<b>29b. Signature and title of certifier</b> 				<b>29c. License number</b> <b>0101015736</b>				<b>29d. Date signed (Month, Day, Year)</b> <b>JAN 30, 1999</b>																																	
<b>30. Name and address of person who completed cause of death (Item 23e) (Type, Print)</b> <b>RONALD A APTER M.D. 6418 CROSSWOODS FALLS CHURCH VA 22041</b>																																									
<b>31. Date filed (Month, Day, Year)</b> <b>FEB 04 1999</b>		<b>32. Registrar's Signature</b> 																																							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit notice.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04579

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bette W. Stambler

2. Date of Death

January 29 1999

Day Year

3. Time of Death

9:58 pm

4e. Facility Name (If not institution, give street and number)

St Agnes Nursing & Rehabilitation Center

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

255-20-7686

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 16, 1923

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Md.

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3004 North Ridge Rd. #333

10f. Zip Code

21043

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Defense Contractor

17. Father's Name (First, Middle, Last)

DeWitt Burton

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Peace

19a. Informant's Name/Relationship (Type, Print)

David Stambler (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Sherwood Ave Pikesville, Md. 21208

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

Feb 2, 1999

20c. Location - City or Town, State

Rockville, Md.

21. Signature of Funeral Service Licensee

Curtis E. Day

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr. Gaithersburg, Md. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Obstructive Pulmonary Disease  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Major Depression

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sandra Sattin MD

29c. License number

D35309

29d. Date signed (Month, Day, Year)

1/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sandra Sattin MD 2850 N Ridge Rd Ellicott City 21043

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04580

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CYNTHIA E SUAH</b>				2. Date of Death Month <b>JANUARY</b> Day <b>25TH</b> Year <b>99</b>		3. Time of Death <b>10:05 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Heartland - Adelphi</b>				4b. City, Town, or Location of Death <b>Adelphi</b>		4c. County of Death <b>Prince Georges</b>		
Funeral Director	5. Social Security Number <b>213 96 0443</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 7, 1936</b>		
	9. Birthplace (State or Foreign Country) <b>Jamaica, W.I.</b>		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>8232 New Hampshire Avenue</b>		10f. Zip Code <b>20903</b>		10g. Citizen of What Country? <b>Jamaica, West Indies</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16. Kind of Business/Industry <b>Child Care</b>		17. Father's Name (First, Middle, Last) <b>Noel Christopher Dillon</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Clementina Jones</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Y. Dillon/Sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8232 New Hampshire Avenue, Silver Spring, MD 20903</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory, Inc. 2/1/99</b>		20c. Location - City or Town, State <b>Beltsville, MD</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Wash., D.C. 20012</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CardioRespiratory Arrest</b> Due to (or as a consequence of): <b>b. SUPRANUCLEAR PALSY</b> Due to (or as a consequence of): <b>c. HTN</b> Due to (or as a consequence of): <b>d. PARKINSON'S DISEASE</b>		Approximate Interval Between Onset and Death <b>10 MIN</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>OSTEOMYELITIS LEFT 5TH METATARSAL</b> <b>SIP amputation</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>00053150</b>		29d. Date signed (Month, Day, Year) <b>January 25th 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHAKUNMALA GUPTA 3503 Perry St. Mt. Rainier, MD 20792</b>		31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3 (3)

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04581

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANITA EVA SHAW				2. Date of Death Month: January Day: 31st Year: 1999		3. Time of Death 12:45A	
	4a. Facility Name (If not institution, give street and number) Carroll County Gen. Hosp.				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 163-22-9910		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) 12/31/1927	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) PENNSYLVANIA					
To Be Completed by Funeral Director	10a. State MD.		10b. County CARROLL		10c. City, Town or Location WESTMINSTER			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 79 W. MAIN ST., APT. M				10f. Zip Code 21157		10g. Citizen of What Country? USA.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry HOME MAKING			
	17. Father's Name (First, Middle, Last) SIDNEY GASKILL				18. Mother's Name (First, Middle, Maiden Surname) ETHEL WILSON			
	19a. Informant's Name/Relationship (Type, Print) BARRY L. SHAW --SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4970 TALL OAKS DR., MONROVIA, MD. 21770			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. JAMES CEMETERY		20c. Location - City or Town, State NEW WINDSOR, MD.		20d. Date 2/2/99	
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Hodgkin's disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Approximate Interval Between Onset and Death One week Five mths							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28d. Describe how injury occurred		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and Title of certifier [Signature], MD		
29c. License number D48006						29d. Date signed (Month, Day, Year) January 31st 1999		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KOFI BODIYER, 280 main. Ave, Westminster, MD 21157								
31. Date filed (Month, Day, Year) FEB 02 1999		32. Registrar's Signature [Signature]						

1924-25 16" in 1924-25  
1925-26 16" in 1925-26

1926-27 16" in 1926-27  
1927-28 16" in 1927-28

1928-29 16" in 1928-29  
1929-30 16" in 1929-30

1930-31 16" in 1930-31  
1931-32 16" in 1931-32

1932-33 16" in 1932-33  
1933-34 16" in 1933-34

1934-35 16" in 1934-35  
1935-36 16" in 1935-36

1936-37 16" in 1936-37  
1937-38 16" in 1937-38

1938-39 16" in 1938-39  
1939-40 16" in 1939-40

1940-41 16" in 1940-41  
1941-42 16" in 1941-42

1942-43 16" in 1942-43  
1943-44 16" in 1943-44

1944-45 16" in 1944-45  
1945-46 16" in 1945-46

1946-47 16" in 1946-47  
1947-48 16" in 1947-48

1948-49 16" in 1948-49  
1949-50 16" in 1949-50

1950-51 16" in 1950-51  
1951-52 16" in 1951-52

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04582

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANK FLETCHER

SLOCOMB

2. Date of Death  
Month Day Year

JAN. 29 1999

3. Time of Death

3:00 PM

4a. Facility Name (If not institution, give street and number)

TAYLOR HOUSE, 8965 DOUBLE HILLS ROAD

4b. City, Town, or Location of Death

DENTON

4c. County of Death

CAROLINE

Funeral  
Director

5. Social Security Number

218-16-8221

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

JAN. 10, 1909

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

CAROLINE

10c. City, Town or Location

DENTON

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

8965 DOUBLE HILLS ROAD

10f. Zip Code

21629

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8College (1-4 or 5+)  
-0-16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

LINOTYPE OPERATOR

16b. Kind of Business/Industry

PRINTING

17. Father's Name (First, Middle, Last)

SAMUEL B. SLOCOMB

18. Mother's Name (First, Middle, Maiden Surname)

MARY ANN KLINE

19a. Informant's Name/Relationship (Type, Print)

GLADYS FAULKNER/ PERS. REP.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

611 MARKET STREET, DENTON, MD 21629

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

NELSON CEMETERY

Date

2-4-99

20c. Location - City or Town, State

NEW CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

Joseph M. Ostrowski

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A.  
200 S. HARRISON ST., EASTON, MD 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Metastatic prostate carcinoma

Approximate  
Interval Between  
Onset and Death

&gt; 3 yrs.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive cardiac failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)  
Taylor House, Denton, MD 21629

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert W. Trever, M.D.

29c. License number

D10938

29d. Date signed (Month, Day, Year)

JAN. 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT W. TREVER, M.D., 7696 OCEAN GATEWAY, EASTON, MD 21601

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

James G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

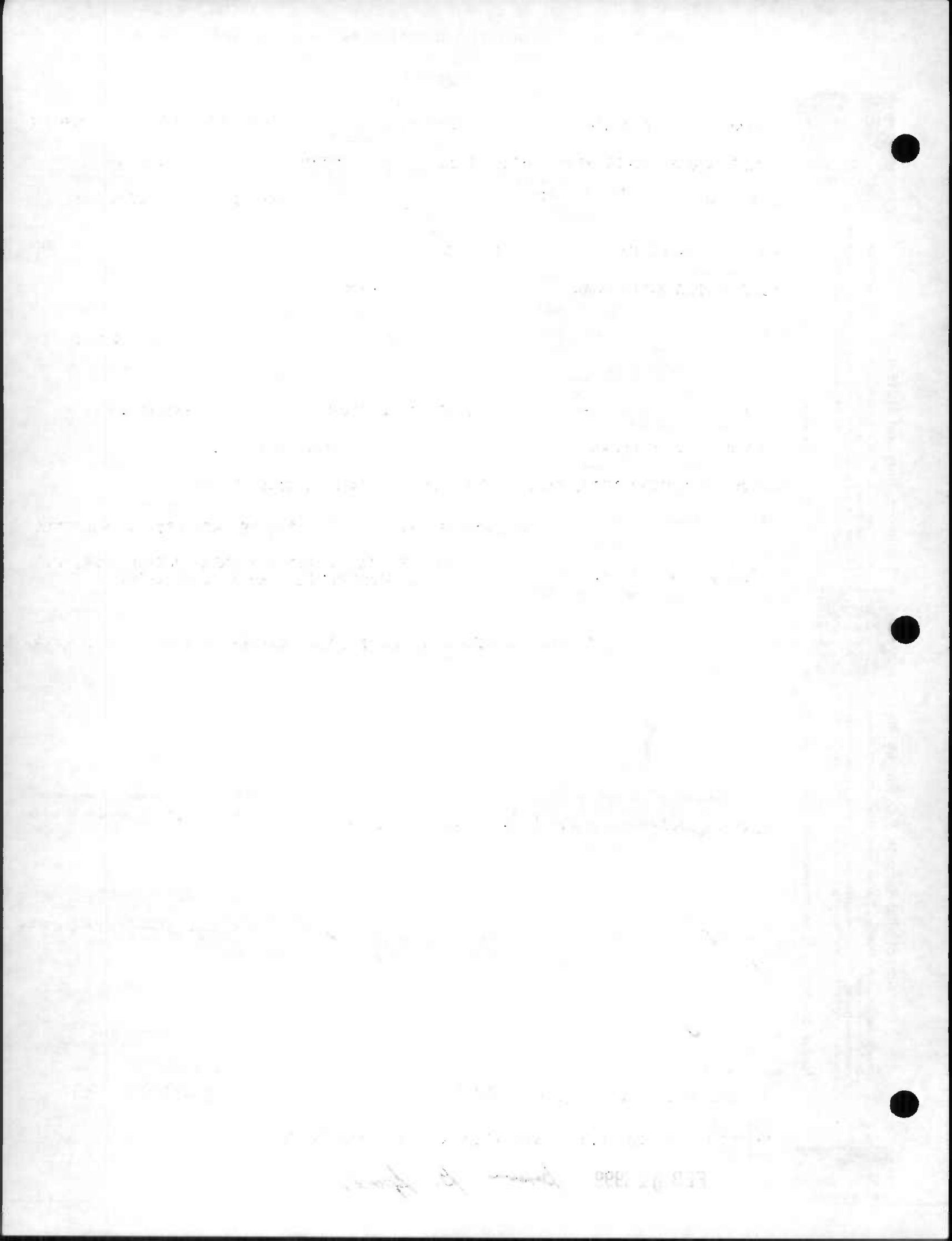
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04583

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILY M. SCHWEITZER				2. Date of Death Month Day Year FEB. 3 1999		3. Time of Death 12:00 PM	
	4a. Facility Name (If not institution, give street and number) 29160 KRISMORE COURT				4b. City, Town, or Location of Death TRAPPE		4c. County of Death TALBOT	
Funeral Director	5. Social Security Number 191-12-5427		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 31, 1913	9. Birthplace (State or Foreign Country) PENNSYLVANIA
	Usual Residence of Decedent							
10a. State MD		10b. County TALBOT		10c. City, Town or Location TRAPPE			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 29160 KRISMORE COURT				10f. Zip Code 21673		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) -0-				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		
17. Father's Name (First, Middle, Last) HENRY R. FISHER				18. Mother's Name (First, Middle, Maiden Surname) LUCY JANE DITZLER				
19a. Informant's Name/Relationship (Type, Print) SUZANNE KOPCZYNSKI, PER.REP				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10711 TODD'S CORNER ROAD, EASTON, MD 21601				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR		20c. Location - City or Town, State 2-4-99 STEVENSVILLE, MD		
21. Signature of Funeral Service Licensee <i>Joseph M. Ostrander</i>				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <i>Aspiration</i> Due to (or as a consequence of):  b. <i>Cerebrovascular disease</i> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  24 hours  1 year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>urinary tract infection</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Matthew J. Fischer MD</i>				29c. License number D52251		29d. Date signed (Month, Day, Year) 2/3/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MATTHEW J. FISCHER 505A Dutchman's Lane Easton MD 21601								
31. Date filed (Month, Day, Year) FEB 05 1999				32. Registrar's Signature <i>B. Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04584

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mirko Zachary Taka</b>				2. Date of Death Month Day Year <b>January 27, 1999</b>				3. Time of Death <b>0315</b>			
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>				4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>N/A</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>3</b>		8. Date of Birth (Month, Day, Year) <b>11 January 27, 1999</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent				10a. State <b>Maryland</b>				10b. County <b>Montgomery</b>			
To Be Completed by Funeral Director	10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>8750 Georgia Avenue #614B</b>			
	10f. Zip Code <b>20910</b>				10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>				16b. Kind of Business/Industry <b>N/A</b>			
	17. Father's Name (First, Middle, Last) <b>Sombele Taka</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Karene Lindor</b>				19a. Informant's Name/Relationship (Type, Print) <b>Sombele Taka /father</b>			
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8750 Georgia Avenue #614B Silver Spring, MD 20910</b>				20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkland Memorial</b>			
	20c. Location - City or Town, State <b>1/30/99 Rockville, Maryland</b>				21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Extreme prematurity</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Maternal abruption</b>			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>D45608</b>				
29d. Date signed (Month, Day, Year) <b>01/27/99</b>				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Ruth Camp MD 12121 Remington DR Silver Spring MD 20902</b>				31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>				
32. Registrar's Signature 				State Registrar								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04585

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ADELINE

TULLER

2. Date of Death  
Month Day Year  
FEBRUARY 2, 19993. Time of Death  
6:50AM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director5. Social Security Number  
578 44 75486. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
88 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
FEB 18 19109. Birthplace (State or Foreign  
Country)  
NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12309 TREETOP DRIVE

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: WHITE15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (13-16)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SIMON DERMAKE

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

AUDREY STARR / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12309 TREETOP DRIVE SILVER SPRING, MARYLAND 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

KING DAVID MEM. GDNS.

Date

2/4/99

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY GOLDBERG MEMORIAL CHAPELS INC.  
1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. CORONARY HEART DISEASE

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas G. Sinderson, MD

29c. License number

D19144

29d. Date signed (Month, Day, Year)

FEBRUARY 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS G. SINDERSON, MD. 6410 ROCKLEDGE DRIVE #200 BETHESDA, Md. 20817

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

2/2/99 0650AM

ADELINE

TULLER

5



WRC

99-0517-041

CHRISTINE

THOMAS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, II, 27 PER MEO G769 3-24-99 WR. **Certificate of Death**

Reg. No. 99 04586

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Christine Thomas

2. Date of Death  
Month Day Year

Jan. 31 1999

3. Time of Death

2:02 a

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

213-70-7643

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

October 25, 1955

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

623 Dover rd.

10f. Zip Code

21601

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House Keeping

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

Walter Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Estella Copper

19a. Informant's Name/Relationship (Type, Print)

Edna Thomas / sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

617 Dover rd. Easton, Md. 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Richards Memorial Prk. 2/6/99 Easton, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Eric D. Dashiell

22. Name and Address of Facility

Dashiell Funeral Services  
322 East ave. Easton, Md. 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

COMPLICATIONS OF COLON CANCER SURGERY AND ATHEROSCLEROTIC

CARDIOVASCULAR DISEASE

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS AND PROBABLE SICKLE CELL TRAIT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

FEB. 01, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

Barbara G. Sparks

State  
RegistrarTHOMAS, CHRISTINE  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text, mostly illegible due to fading. Some words like "The", "and", "of" are visible.

Handwritten text, mostly illegible due to fading. Some words like "The", "and", "of" are visible.

Handwritten text, mostly illegible due to fading. Some words like "The", "and", "of" are visible.

Handwritten text, mostly illegible due to fading. Some words like "The", "and", "of" are visible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04587

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA RUTH TAYLOR

2. Date of Death

Month Day Year  
FEB 2 1999

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

218-30-1438

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT. 23, 1932

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

QUEEN ANNE

10c. City, Town or Location

GRASONVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

120 ROBINSON'S LANE

10f. Zip Code

21638

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
07

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATOR

16b. Kind of Business/Industry

PASTORIAL MINISTRY

17. Father's Name (First, Middle, Last)

OLIVER WEATHERLY

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA WILSON

19a. Informant's Name/Relationship (Type, Print)

LENWOOD E. TAYLOR, SR./SPOUSE 120 ROBINSON'S LANE, GRASONVILLE, MD. 21638

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BRYANS CHURCH CEMETERY 2/7/99 GRASONVILLE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Eric L. Dashiell

22. Name and Address of Facility

DASHIELL FUNERAL SERVICES  
322 EAST AVE EASTON, MD. 21601

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gram positive sepsis with hypotension.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes mellitus with end stage renal disease.

Due to (or as a consequence of):

11 years

c. Peripheral vascular disease

Due to (or as a consequence of):

years

d. Hypertension

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

clotted AV graft graft.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Syed I. Ali MD

29c. License number

D 46020

29d. Date signed (Month, Day, Year)

2/2/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SYED I. ALI, M.D. 506 IDLEWILD AVE. EASTON, MD. 21601

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04588

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MYRON T UPPERCO</b>				2. Date of Death Month <b>2</b> Day <b>2</b> Year <b>99</b>		3. Time of Death <b>4:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>LOOK ABOUT MANOR</b>				4b. City, Town, or Location of Death <b>WESTMINSTER</b>		4c. County of Death <b>CARROLL</b>	
Funeral Director	5. Social Security Number <b>214 10 0053</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG 15 1920</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>CARROLL</b>		10c. City, Town or Location <b>WESTMINSTER</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>551 OLD WESTMINSTER PIKE</b>				10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLERK</b>			16b. Kind of Business/Industry <b>RAILROAD</b>		
	17. Father's Name (First, Middle, Last) <b>JESSE UPPERCO</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY RUTH TAYLOR</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>LINA FERGUSON/DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3101 UNIONTOWN ROAD WESTMINSTER, MD 21158</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PIPE CREEK CEMETERY</b>		20c. Location - City or Town, State <b>2/5/99 LINWOOD, MD.</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>PO: H'S FUNERAL HOME &amp; CHAPEL 412 WASHINGTON ROAD WESTMINSTER, MARYLAND 21157</b>			
	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	e. <b>METASTATIC CARCINOMA OF THE PANCREAS</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>CARE HOME</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>DO 1663</b>		29d. Date signed (Month, Day, Year) <b>2/2/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>VINCENT J. FIOCCO JR</b>		<b>906 C WASHINGTON RD WESTMINSTER, MD 21157</b>						
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04589

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RAY E. VANOVER</b>				2. Date of Death Month <b>FEB.</b> Day <b>3,</b> Year <b>1999</b>		3. Time of Death <b>7:30 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>3903 38th ST.</b>				4b. City, Town, or Location of Death <b>BRENTWOOD</b>		4c. County of Death <b>PRINCE GEORGES</b>		
Funeral Director	5. Social Security Number <b>211-24-7110</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 10, 1933</b>		
	9. Birthplace (State or Foreign Country) <b>N. CAROLINA</b>		10a. State <b>MD.</b>		10b. County <b>PRINCE GEORGES</b>		10c. City, Town or Location <b>BRENTWOOD</b>		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3903 38th ST.</b>		10f. Zip Code <b>20722</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CARPENTER</b>		16b. Kind of Business/Industry <b>LOCAL 1145, CARPENTERS UNION</b>				
	17. Father's Name (First, Middle, Last) <b>ALONZO VANOVER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ALICE SHAW</b>				
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>RHEA QUESENBERY/DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3702 36th ST., MT. RAINIER, MD. 20712</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FT. LINCOLN CEMETERY</b>		Date <b>2/6/99</b>		20c. Location - City or Town, State <b>BRENTWOOD, MD.</b>		
	21. Signature of Funeral Service Licensee  <b>MOO091</b>				22. Name and Address of Facility <b>CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Lung cancer metastatic</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>6 months</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number <b>D34403</b>		29d. Date signed (Month, Day, Year) <b>2/3/99</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Andrew S. O'Brien MD 3231 Spawton Lane A6 Bowie MD 20715</b>									
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04590

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MERCEDES VOLKERT</b>				2. Date of Death Month Day Year <b>FEBRUARY 1 1999</b>		3. Time of Death <b>6:06 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-26-8017</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB 2 1923</b>	
	10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Marriottsville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Usual Residence of Decedent								
10e. Street and Number <b>7352 Brangles Road</b>				10f. Zip Code <b>21104</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>			16b. Kind of Business/Industry <b>domestic</b>		
17. Father's Name (First, Middle, Last) <b>Eston Mercier</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Y. Healey</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Howard M. Volkert Sr. (spouse)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7352 Brangles Rd., Marriottsville, MD 21104</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lake View Memorial</b>		Date <b>2-4-99</b>		20c. Location - City or Town, State <b>Sykesville, MD</b>	
21. Signature of Funeral Service Licensee <b>Paul Hight Herbert</b>					22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel P.O. Box 195 Sykesville, MD 21784</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Clifford S. Faber, MD</b>					29c. License number <b>024970</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 1, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CLIFFORD S. FABER, MD NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MARYLAND</b>								
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>			32. Registrar's Signature <b>Beverly G. Sparks</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04591

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy Fay Watts</b>						2. Date of Death Month Day Year <b>February 4, 1999</b>		3. Time of Death <b>2:00 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Manor Care Nursing Home</b>						4b. City, Town, or Location of Death <b>Potomac</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>318-12-3683</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 17, 1914</b>		9. Birthplace (State or Foreign Country) <b>Illinois</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>North Potomac</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>15513 Quince Valley Terrace</b>				10f. Zip Code <b>20878</b>		10g. Citizen of What Country? <b>United States</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>			16b. Kind of Business/Industry <b>Elementary School</b>			
17. Father's Name (First, Middle, Last) <b>Lee Robinson</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Inez Good</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Jane Clark/Daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15513 Quince Valley Terrace, North Potomac, MD. 20878</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunland Memorial Park</b>		Date <b>Feb 10, 1999</b>		20c. Location - City or Town, State <b>Sun City, Arizona</b>		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>DeVol Funeral Home 10 East Deer Park Drive, Gaithersburg, MD. 20877</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Sepsis</b> Due to (or as a consequence of):  b. <b>Urinary Tract Infection</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dehydration, Dementia, Hypertension</b>										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 23911</b>		29d. Date signed (Month, Day, Year) <b>February 4, 1999</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David A. Blass, M.D., 9410 Old Georgetown Road, Bethesda, Maryland 20814</b>										
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

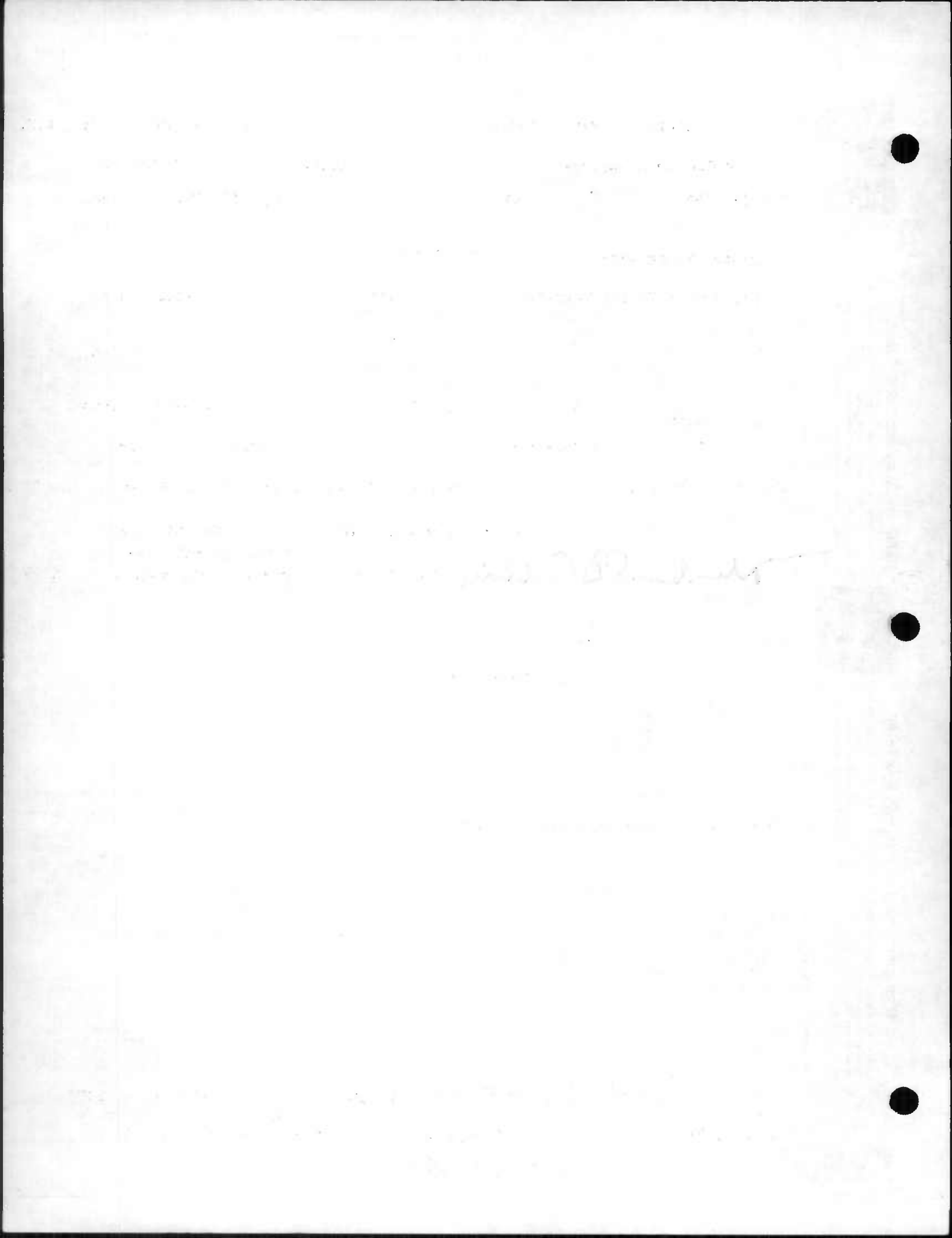
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04592

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN G. WEINBERG</b>				2. Date of Death Month Day Year <b>02.02.1999</b>		3. Time of Death <b>2:46 PM</b>												
	4a. Facility Name (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY</b>												
Funeral Director	5. Social Security Number <b>214.74.6023</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>10.15.1904</b>	9. Birthplace (State or Foreign Country) <b>POLAND</b>											
	Usual Residence of Decedent																		
10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>SILVER SPRING</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
10e. Street and Number <b>1135 UNIVERSITY BLVD. WEST</b>				10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>USA</b>													
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>													
17. Father's Name (First, Middle, Last) <b>CHARLES SHERMAN</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>"UNOBTAINABLE"</b>														
19a. Informant's Name/Relationship (Type, Print) <b>LEON WAYNBERG/SON</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2002 LOBELIA DR, CEDAR PARK, TEXAS 78613</b>														
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING DAVID MEMORIAL GDNS</b>		Date <b>2.4.99</b>		20c. Location - City or Town, State <b>FALLS CHURCH, VA</b>												
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>aortic stenosis</b></td> <td rowspan="4">Approximate Interval Between Onset and Death <b>25 yrs</b></td> </tr> <tr> <td>b.</td> <td><b>dilated cardiomyopathy</b></td> <td rowspan="3"><b>1 yr</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a.	<b>aortic stenosis</b>	Approximate Interval Between Onset and Death <b>25 yrs</b>	b.	<b>dilated cardiomyopathy</b>	<b>1 yr</b>	c.		d.	
Immediate Cause (Final disease or condition resulting in death)	a.	<b>aortic stenosis</b>	Approximate Interval Between Onset and Death <b>25 yrs</b>																
	b.	<b>dilated cardiomyopathy</b>		<b>1 yr</b>															
	c.																		
	d.																		
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sepsis</b>																			
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																			
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
			28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number <b>40661</b>		29d. Date signed (Month, Day, Year) <b>2/2/99</b>											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Alan Schneider 10313 Georgia Ave #307 SSMD 20902</b>																			
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>			32. Registrar's Signature 																

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

WEINBERG, HELEN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04593

SEPTIAN LARON WEST

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SEPTIAN LaVAR WEST</b>				2. Date of Death Month <b>JANUARY</b> Day <b>29</b> , Year <b>1999</b>		3. Time of Death <b>17:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1608 MARLBORO PARK</b>				4b. City, Town, or Location of Death <b>UPPER MARLBORO</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>577-06-4645</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>17</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>February 5 1981</b>	9. Birthplace (State or Foreign Country) <b>Wash., DC</b>
	Usual Residence of Decedent							
10a. State <b>D.C.</b>		10b. County <b>--</b>		10c. City, Town or Location <b>Washington</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>622 11th St., N.E.</b>				10f. Zip Code <b>20002</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Telecommunications</b>		16b. Kind of Business/Industry <b>Telecommunications</b>		
17. Father's Name (First, Middle, Last) <b>William L. West</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Patricia Y. Reed</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Patricia Y. Reed/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>622 11th St., N.E. Wash., DC 20002</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glenwood Cemetery</b>		Date <b>2-6-99</b>		20c. Location - City or Town, State <b>Washington, D.C.</b>
21. Signature of Funeral Service Licensee <i>Sharon Johnson-Salley</i>				22. Name and Address of Facility <b>Capitol Mortuary</b> <b>1425 Maryland Ave., NE Wash., DC 20002</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Causa (Final disease or condition resulting in death) <b>a. Multiple Gunshot Wounds</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>1-29-99</b>		28b. Time of Injury <b>4:40p M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject Shot</b>
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Side of Road</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1608 Marlboro Park</b>		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 30, 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

3. Time of Death

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LOUISE S. WHITNEY

2. Date of Death

JANUARY 24 1999

3. Time of Death

1410

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

8505 SPRINGVALE ROAD

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

183-14-3565

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 28, 1912

9. Birthplace (State or Foreign Country)

MASSACHUSETTS

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8505 SPRINGVALE ROAD

10f. Zip Code

20910

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

SCHOOL SYSTEM

17. Father's Name (First, Middle, Last)

WILLIAM WHITNEY

18. Mother's Name (First, Middle, Maiden Surname)

SARAH STERLING

19a. Informant's Name/Relationship (Type, Print)

PAUL MERICLE/GUARDIAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

303 DUCK ROAD KITTY HAWK, NC 27949

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. MARK EPISCOPAL CEMETERY 1/29/99 SILVER SPRING

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Anthony S. Dimery

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD. [Signature]

29c. License number

015236

29d. Date signed (Month, Day, Year)

JANUARY 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL MAGGOW, MD. (OME) 11125 ROCKVIEW PIKE, ROCKVILLE MD 20851

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

Benita S. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04595

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) PERRY W. WIGHTMAN				2. Date of Death Month Day Year JANUARY 28, 1999		3. Time of Death 6:30 PM			
4a. Facility Name (If not institution, give street and number) BROOKE GROVE NURSING HOME				4b. City, Town, or Location of Death SANDY SPRING		4c. County of Death MONTGOMERY			
5. Social Security Number 215 20 3565		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 30, 1926		9. Birthplace (State or Foreign Country) WASHINGTON, D.C.	

Funeral  
Director

Usual Residence of Decedent				10c. City, Town or Location LAUREL				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. State DELAWARE		10b. County SUSSEX		10f. Zip Code 19956		10g. Citizen of What Country? UNITED STATES			
10e. Street and Number 12 CHIPMAN'S CHASE DRIVE		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FOREMAN		16b. Kind of Business/Industry TELEPHONE COMPANY					

To Be Completed by Funeral Director

17. Father's Name (First, Middle, Last) PERRY EARL WIGHTMAN				18. Mother's Name (First, Middle, Maiden Surname) BESSIE S. MEUSHAW			
19a. Informant's Name/Relationship (Type, Print) SHIRLEY A. WIGHTMAN, WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 CHIPMAN'S DRIVE, LAUREL, DELAWARE 19956			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) UNION CEMETERY		Date 2/2/99		20c. Location - City or Town, State BURTONSVILLE, MD.	
21. Signature of Funeral Service Licensee Muriel H. Barber				22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882			

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. glioblastoma multiforme, grade IV Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 5 months	
---	--	--	--

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
--	--

29b. Signature and title of certifier STAFF PHYSICIAN		29c. License number D42046		29d. Date signed (Month, Day, Year) January 28, 1999	
--	--	-------------------------------	--	---	--

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GRACE BROOKE HUFFMAN, MD. 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 20860	
--	--

31. Date filed (Month, Day, Year) FEB 01 1999		32. Registrar's Signature B. Sparks	
--	--	--	--

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04596

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>LUCY M. WILLIAMS</b>		2. Date of Death Month <b>January</b> Day <b>31</b> Year <b>1999</b>		3. Time of Death <b>1800 P</b>	
4a. Facility Name (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>		4b. City, Town, or Location of Death <b>Rockville MD</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>521-46-0503</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.	
8. Date of Birth Month, Day, Year <b>June 19, 1937</b>		9. Birthplace (State or Foreign Country) <b>Colorado</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Germantown</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>19124 Staley Bridge Road</b>		10f. Zip Code <b>20876</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Technical Information Specialist</b>		16b. Kind of Business/Industry <b>U.S. Government</b>	
17. Father's Name (First, Middle, Last) <b>George H. Pigford</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Docre Carr</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Melvin Williams (Husband)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19124 Staley Bridge Rd., Germantown, MD 20876</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Mem. Park</b>		20c. Location - City or Town, State <b>Rockville, MD</b>	
21. Signature of Funeral Service Licensee <i>George R. Snowden</i>		22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>METASTATIC BREAST CANCER</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					Approximate Interval Between Onset and Death <b>2 YEARS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Chibi Agard, M.D.</b>		29c. License number <b>MARYLAND D42452</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 1, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. CHITRA RAJAPAL, M.D. 18111, PRINCE PHILIP DRIVE, SUITE 327, OLAKE, MD 20832</b>					
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature <i>B. Sparks</i>			

To Be Completed by Funeral Director

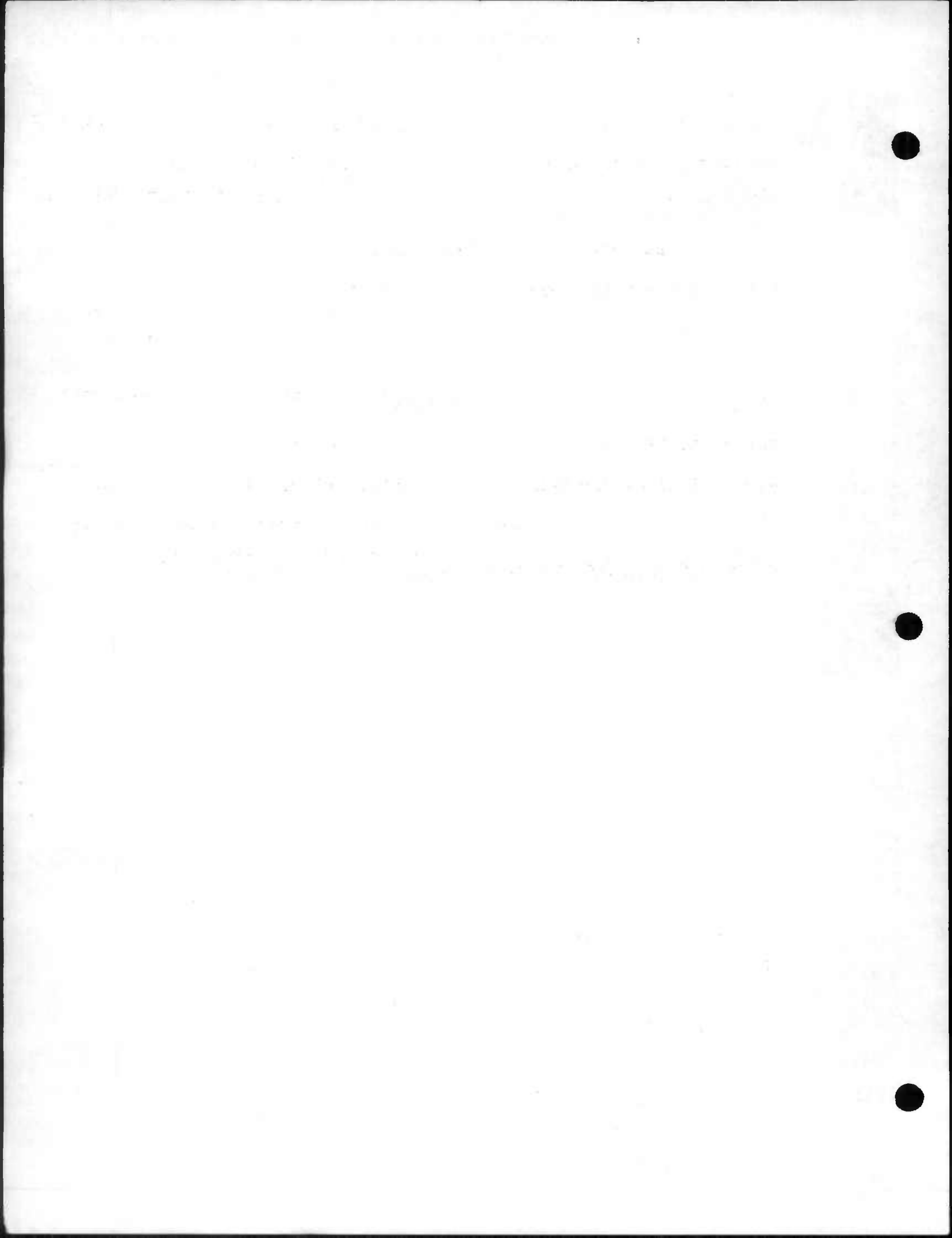
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04597

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Albert Willis</b>						2. Date of Death Month Day Year <b>January 28, 1999</b>		3. Time of Death <b>3:00 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>11555 Rockville Pike</b>						4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>439-36-8312</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 7, 1931</b>		9. Birthplace (State or Foreign Country) <b>Missouri</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Potomac</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>8607 Hidden Hill Lane</b>				10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>United States</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korean</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (14 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Health Physicist</b>				16b. Kind of Business/Industry <b>U.S. Government</b>					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Walter Willis</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Moritzky</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Wynnora Willis/Wife</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8607 Hidden Hill Lane, Potomac, Maryland 20854</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>				20c. Location - City or Town, State <b>Bethesda, Maryland</b>		20d. Date <b>January 30, 1999</b>			
	21. Signature of Funeral Service Licensee  <b>MO1126</b>		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Coronary Artery Disease</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Obesity</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
											24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
											24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Workplace</b>									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
State Registrar	29b. Signature and title of certifier 				29c. License number <b>D35336</b>		29d. Date signed (Month, Day, Year) <b>January 29, 1999</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Deena Shapiro, M.D. 10810 Connecticut Avenue, Kensington, Maryland 20895</b>											
	31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>		32. Registrar's Signature 									



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04598

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joan Wingo</b>		2. Date of Death Month <b>February</b> Day <b>1</b> Year <b>1999</b>		3. Time of Death <b>6:23 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>None</b>
Funeral Director	5. Social Security Number <b>224-56-5301</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>May 30, 1941</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>West Virginia</b>	10b. County <b>Mercer</b>	10c. City, Town or Location <b>Bluefield</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>316 Coppinger Street</b>		10f. Zip Code <b>24701</b>		10g. Citizen of What Country? <b>United States of America</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>
	17. Father's Name (First, Middle, Last) <b>Beverly Washington Angles, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Lee Edwards</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Gordon E. Wingo/ Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>24701</b> <b>316 Coppinger Street, Bluefield, West Virginia</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maplewood Cemetery</b>		20c. Location - City or Town, State <b>February 4, 1999 Tazwell, Virginia</b>
	21. Signature of Funeral Service Licensee <b>Howard A. Carson</b>		22. Name and Address of Facility <b>Peery &amp; St. Clair Funeral Home</b> <b>111 Ben Bolt Avenue, Tazwell, Virginia 24651</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Colon Cancer</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>				
	Approximate Interval Between Onset and Death <b>Six Months</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>P. Kumar MD</b>			
29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>February 1, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Pallavi P. Kumar MD 600 N. Wolfe Street Baltimore MD 21287</b>					
31. Date filed (Month, Day, Year) <b>FEB 03 1999</b>		32. Registrar's Signature <b>B. Sparks</b>			

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene 99 04599

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SUSIE MAE MC CUTCHEN WILLIAMS</b>				2. Date of Death Month Day Year <b>FEBRUARY 4, 1999</b>		3. Time of Death <b>12:25 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGE</b>	
Funeral Director	5. Social Security Number <b>263-32-7800</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG. 14, 1922</b>	9. Birthplace (State or Foreign Country) <b>ASHBURN, GEORGIA</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>CHARLES</b>	10c. City, Town or Location <b>WALDORF</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>5903 HERRING COURT</b>			10f. Zip Code <b>20603</b>		10g. Citizen of What Country? <b>UNITED STATES</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SELF-EMPLOYED RETAILER</b>			16b. Kind of Business/Industry <b>CLOTHING STORE</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>MINGO MC CUTCHEN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LULA PRESSLEY MC CUTCHEN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>BARBARA W. O'DELL / DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5903 HERRING COURT, WALDORF, MARYLAND 20603</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PINEGROVE CEMETERY</b>		Date <b>2/10/99</b>		20c. Location - City or Town, State <b>FT. PIERCE, FLORIDA</b>	
	21. Signature of Funeral Service Licensee  <b>LYDIA C. THORNTON JOHNSON MO0583</b>		22. Name and Address of Facility <b>THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640</b>					
Physician /Medical Examiner	23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death  <b>YEARS</b>
	e. <b>MULTIPLE MYELOMA</b> Due to (or as a consequence of):							
	b. Due to (or as a consequence of):							
	c. Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number <b>DD02975</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 5, 1999</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DANIEL HOWELL, MD 11345 PEMBROOK SQUARE, SUITE 104 WALDORF, MARYLAND 20603</b>							
	31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04600

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John W. WATERS</b>				2. Date of Death Month <b>January</b> Day <b>28</b> Year <b>1999</b>		3. Time of Death <b>1010</b>													
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>													
Funeral Director	5. Social Security Number <b>215-22-7976</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>7-21-21</b>	9. Birthplace (State or Foreign Country) <b>MD</b>														
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>SOMERSET</b>	10c. City, Town or Location <b>Princess Anne</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
	10e. Street and Number <b>11974 Edgehill Terrace</b>			10f. Zip Code <b>21853</b>		10g. Citizen of What Country? <b>U.S.</b>														
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>			16b. Kind of Business/Industry <b>Security Guard Agency</b>														
	17. Father's Name (First, Middle, Last) <b>Sumner Waters</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Etha Waters</b>															
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Victoria Wrespiess / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1831 Margaret St. Phila. PA 19124</b>															
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veterans Cemetery</b>		Date <b>2-3-99</b>		20c. Location - City or Town, State <b>Hurlock, MD</b>													
	21. Signature of Funeral Service Licensee <b>Anthony E. Ward</b>				22. Name and Address of Facility <b>Anthony E. Ward Funeral Home 30639 Hampden Ave. Princess Anne, MD 21853</b>															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>Septicemia</b></td> <td>Approximate Interval Between Onset and Death <b>60 HRS</b></td> </tr> <tr> <td>b.</td> <td><b>Electrolyte Imbalance</b></td> <td><b>60 HRS</b></td> </tr> <tr> <td>c.</td> <td><b>Dehydration</b></td> <td><b>60 HRS</b></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	<b>Septicemia</b>	Approximate Interval Between Onset and Death <b>60 HRS</b>	b.	<b>Electrolyte Imbalance</b>	<b>60 HRS</b>	c.	<b>Dehydration</b>	<b>60 HRS</b>	d.	
Immediate Cause (Final disease or condition resulting in death)	a.	<b>Septicemia</b>	Approximate Interval Between Onset and Death <b>60 HRS</b>																	
	b.	<b>Electrolyte Imbalance</b>	<b>60 HRS</b>																	
	c.	<b>Dehydration</b>	<b>60 HRS</b>																	
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>atrial fibrillation</b> <b>acute pneumonia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
				28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)														
				28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Helen M. Baldado</b>		29c. License number <b>16840</b>		29d. Date signed (Month, Day, Year) <b>1/29/99</b>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Helen M. BALDADO, M.D. 547 F RIVERSIDE DR SALISBURY, MD</b>																				
31. Date filed (Month, Day, Year) <b>FEB - 2 1999</b>		32. Registrar's Signature <b>Denise B. Sparks</b>																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

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1950-1951

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04601

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN H.H. YANG

2. Date of Death

Month Day Year  
Jan 29 1999

3. Time of Death

12:50AM

4a. Facility Name (If not Institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-46-7803

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT. 12, 1901

9. Birthplace (State or Foreign Country)

CHINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2002 GATEWOOD PLACE

10f. Zip Code

20903

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: CHINESE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSE

16b. Kind of Business/Industry

HEALTH CARE SERVICES

17. Father's Name (First, Middle, Last)

TING HAN

18. Mother's Name (First, Middle, Maiden Surname)

YANG HAN

19a. Informant's Name/Relationship (Type, Print)

GEORGE YANG - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6625 MARYWOOD ROAD, BETHESDA, MARYLAND 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ROCK CREEK CEMETERY

Data

2-1-99

20c. Location - City or Town, State

WASHINGTON, DC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904

Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiomyopathy

Due to (or as a consequence of):

c. pneumonia, left lung

Due to (or as a consequence of):

d. stroke

4/19/99

4/19/99

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1) Left Breast Cancer

2) generalized postmenopausal osteoporosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D13339

29d. Date signed (Month, Day, Year)

1/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. CHANCHEN 8824 Cunningham Dr. Berwyn Heights MD

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 01602

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline Ora Young

2. Date of Death

February 2, 1999

3. Time of Death

7:10 AM

4a. Facility Name (If not institution, give street and number)

3205 Prince Henry Court

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-09-7887

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 1, 1917

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3205 Prince Henry Court

10f. Zip Code

20832

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

Furman T. Replogle

18. Mother's Name (First, Middle, Maiden Surname)

Hazel C. Whistler

19a. Informant's Name/Relationship (Type, Print)

Kathleen Millard (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3205 Prince Henry Court, Olney, MD 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

2/5/99

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

Eric S. Scordo

22. Name and Address of Facility

Francis J. Collins Funeral Home  
Inc. 500 University Blvd. West  
Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic colon cancer

Approximate Interval Between Onset and Death

years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Eric S. Scordo

29c. License number

D38457

29d. Date signed (Month, Day, Year)

FEBRUARY 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. GONK MD, 1811 PRINCE PHILIP DR, OLNEY MD 20853

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04603

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SAM ZIDEL</b>				2. Date of Death Month Day Year <b>01.30.1999</b>		3. Time of Death <b>3:15 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>POTOMAC VALLEY NURSING HOME</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>480.07.4484</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>09.17.1916</b>	
	9. Birthplace (State or Foreign Country) <b>IOWA</b>		10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>ROCKVILLE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1235 POTOMAC VALLEY ROAD</b>		10f. Zip Code <b>20850</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>RETAIL</b>		16b. Kind of Business/Industry <b>ALASKA PIPELINE</b>				
17. Father's Name (First, Middle, Last) <b>HARRY ZIDEL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MINNIE WILKES</b>				
19a. Informant's Name/Relationship (Type, Print) <b>SIDNEY BRESSLER/BROTHER IN LAW</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>761 SEQUOIA TRAIL, MAITLAND, FLORIDA 32751</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING DAVID MEMORIAL GDNS.2.1.99</b>		20c. Location - City or Town, State <b>FALLS CHURCH, VIRGINIA</b>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>DIABETES</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Approximate Interval Between Onset and Death <b>YEARS</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RENAL FAILURE</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D20516</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 1, 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. JOEL SCHULMAN, 9410 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND 20894</b>								
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

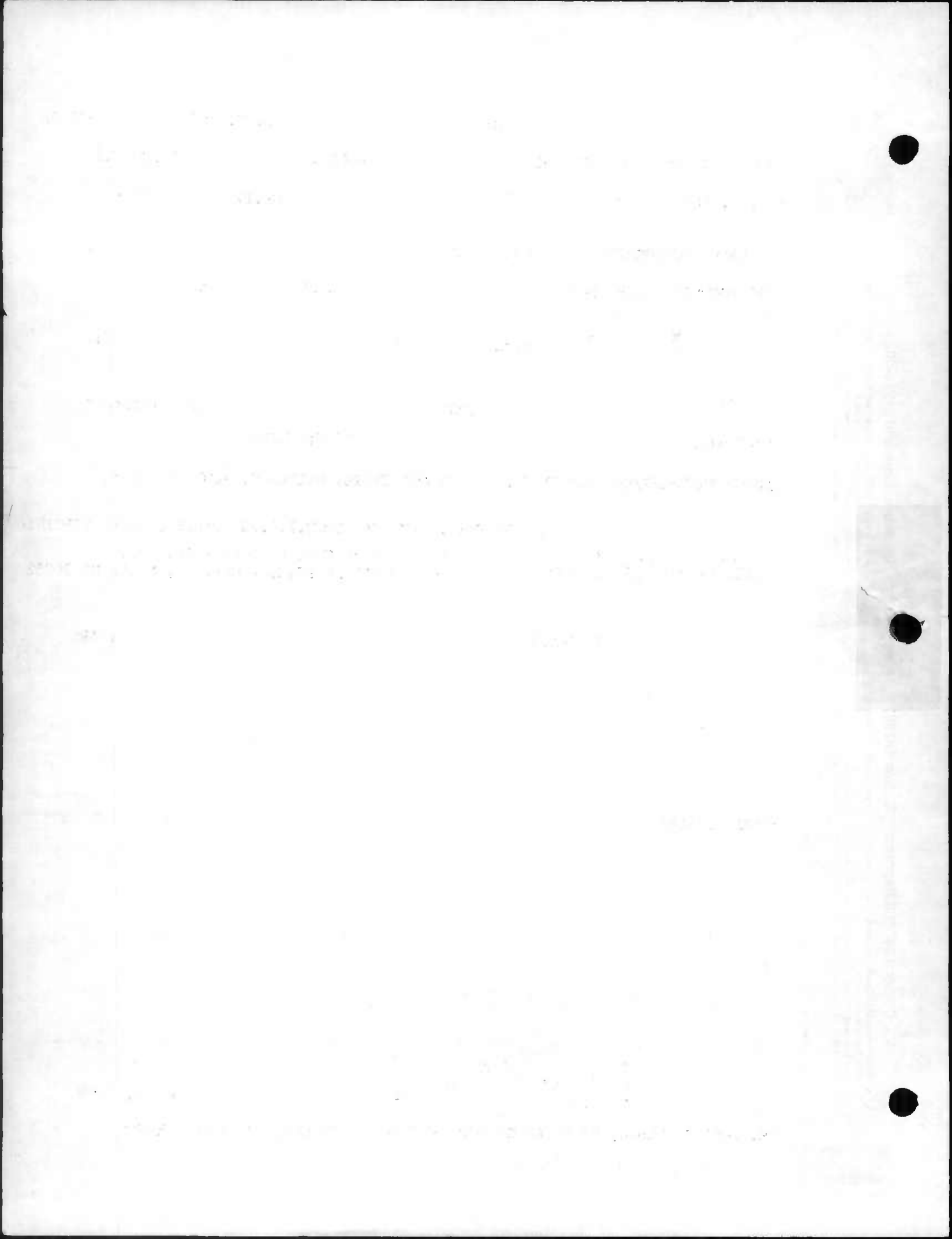
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04604

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Violet B. Zelonis</b>				2. Date of Death Month Day Year <b>February 2, 1999</b>		3. Time of Death <b>6:15 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Wilson Health Care Center</b>				4b. City, Town, or Location of Death <b>Gaithersburg</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>193-14-7274</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 12, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Kensington</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>5121 Flanders Avenue</b>		10f. Zip Code <b>20895</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Meade Barnett</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ora Truax</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Charles A. Zelonis, Jr. / son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5121 Flanders Avenue, Kensington, Maryland 20895</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. Date <b>February 5, 1999</b>		20d. Location - City or Town, State <b>Silver Spring, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>Barbara M. Muller-Lawrence</i>		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier <i>Joe R. Schulman</i>		29c. License number <b>020516</b>		29d. Date signed (Month, Day, Year) <b>February 3, 1999</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Joe R. Schulman, M.D. 9410 Old Georgetown Road, Bethesda, Maryland 20814</b>							
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

**Physician  
/Medical  
Examiner**

**Funeral  
Director**

1. Decedent's Name (First, Middle, Last) <b>FRANK ALSTON</b>				2. Date of Death Month <b>FEBRUARY</b> Day <b>16</b> Year <b>1999</b>		3. Time of Death <b>18:00</b>	
4a. Facility Name (If not institution, give street and number) <b>MERLY MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
5. Social Security Number <b>250-46-6285</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT 20 1931</b>	
9. Birthplace (State or Foreign Country) <b>NC</b>							
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town, or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>539 Bloom St.</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNK</b> College (1-4 or 5+) <b>UNK</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Long Shoreman</b>		16b. Kind of Business/Industry <b>Shipping</b>	
17. Father's Name (First, Middle, Last) <b>UNK</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lee Alston</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Shirleyne Brown daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5010 Charles St. Philadelphia, PA 19124</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION Cemetery</b>		20c. Location - City or Town, State <b>Landdowne, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Albert P. Wylie Funeral Home PA 638 N. Gilmor St. Baltimore, MD 21217</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Due to (or as a consequence of): <b>b. Chronic Obstructive Pulmonary Disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b></p> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number <b>P10422</b>		29d. Date signed (Month, Day, Year) <b>February 16, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>22 S. Greene St. Baltimore, MD 21201</b>							
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Item#5 perFHG768 2/18/99 EW

99 04606

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Larry Austin

2. Date of Death

Month Day Year  
February 14 1999

3. Time of Death

11:05 PM

4a. Facility Name (If not institution, give street and number)

Sindi Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

217-66-5762

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12 31 56

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4800 Seton Drive

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeping

16b. Kind of Business/Industry

St. Joseph Hospital

17. Father's Name (First, Middle, Last)

Mayer Austin

18. Mother's Name (First, Middle, Maiden Surname)

Rosie Marshall

19a. Informant's Name/Relationship (Type, Print)

Cenice Austin-Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2806 Ruslaski Highway, Baltos. Md

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Vostell Cemetery

Date

2-19-99 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jeff Miller

22. Name and Address of Facility

Jeff Miller P.E. Funeral & Services  
1639 N. Broadway Baltimore, Md. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Disseminated Mycobacterium Avium-intracellulare

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acquired immunodeficiency syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Irlander M.D.

29c. License number

P 12343

29d. Date signed (Month, Day, Year)

February 14, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

D. Irlander M.D.

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Larry Austin  
known as  
PT known as



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04607

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Peter Bench</b>				2. Date of Death Month: <b>FEB.</b> Day: <b>5,</b> Year: <b>1999</b>		3. Time of Death <b>8:55 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Fairfield Nursing Center</b>				4b. City, Town, or Location of Death <b>Crownsville</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>705-10-3399</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) <b>JULY 1, 1915</b>	9. Birthplace (State or Foreign Country) <b>Massachusetts</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Crownsville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1454 Fairloop Road</b>				10f. Zip Code <b>21032</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>8</b> College (1-4or 5+):				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Brakeman</b>			16b. Kind of Business/Industry <b>Railroad</b>		
17. Father's Name (First, Middle, Last) <b>August Bench</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Antonia (Unobtainable)</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Albert Whitehead - nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. Box 26, Baltimore St., Savage, Md. 20763</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Pk.</b>		20c. Location - City or Town, State <b>Elkridge, Md.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 7250 Washington Blvd., Elkridge, Md. 21075</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Sepsis</b> Due to (or as a consequence of): <b>b. Fecal - urinary fistula</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Coronary artery disease</b>								Approximate Interval Between Onset and Death <b>2 days</b> <b>2 months</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary artery disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>038958</b>		29d. Date signed (Month, Day, Year) <b>2/5/99</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dafeet Singh 1413 Annapolis Road #106 Odenton MD 21113</b>									
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>				32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04608

Item: 7 per F.H G-768 2/18/99 reb

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William J. Beil, Sr.

2. Date of Death

Month  
2

Day  
14

Year  
99

3. Time of Death

9:30pm

4a. Facility Name (If not institution, give street and number)

533 Backriver Neck Road

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore Co.

Funeral  
Director

5. Social Security Number

217-14-1910

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar 28, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

533 Backriver Neck Road

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Police Officer

16b. Kind of Business/Industry

Baltimore City Police Department

17. Father's Name (First, Middle, Last)

William A. Beil

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Coroum

19a. Informant's Name/Relationship (Type, Print)

William J. Beil, Jr (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4328 Evans Chapel Road, Baltimore, Maryland 21211

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Cemetery

Date

2/16/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home  
3818 Roland Avenue, Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

LUNG CANCER

Approximate Interval Between Onset and Death

3 MONTHS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Madhu Chaudhry

29c. License number

D41406

29d. Date signed (Month, Day, Year)

2/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MADHU CHAUDHRY FRANKLIN SQUARE HOSPITAL CENTER  
9000 FRANKLIN SQUARE DRIVE BALTIMORE MD 21231

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

Shirley B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1947-1948  
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04609

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>WILLIAM CROMIE</b>						2. Date of Death Month <b>FEBRUARY</b> Day <b>14</b> Year <b>1999</b>		3. Time of Death <b>11:47 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>BALTIMORE VETERANS HOSPITAL</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE CITY</b>	
5. Social Security Number <b>215-12-3446</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB 27 1921</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
Usual Residence of Decedent									
10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>207 N AMITY STREET APT 12</b>				10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>42/45</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) <b>12th grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MERCHANT MARINE</b>		16b. Kind of Business/Industry <b>MILITARY</b>			
17. Father's Name (First, Middle, Last) <b>CHESTER CROMIE</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Joseph Cromier/Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>519 ST. Patrick Rd, Baltimore Maryland 21206</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST</b>		Date <b>2-18</b>		20c. Location - City or Town, State <b>OWINGS MILLS MD</b>			
21. Signature of Funeral Service Licensed 				22. Name and Address of Facility <b>WILLIAM C BROWN COMMUNITY F/H PA 1206 W NORTH AVENUE</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> <b>ATRIAL FIBRILLATION</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>P10230</b>		29d. Date signed (Month, Day, Year) <b>February 14, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NEERAJ CHOPRA 10 NORTH GREENE STREET, BALTIMORE, MARYLAND 21201</b>									
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature 							

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04610

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MICHELE ANTIONETTE CONYERS

2. Date of Death

FEB 13 1999

3. Time of Death

02:49 HRS

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

ER HARFORD MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

HARFORD

4c. County of Death

HARFORD

5. Social Security Number

220-82-6308

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUN 8 1960

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HARFORD

10c. City, Town or Location

ABERDEEN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

106 SPESUTIA ROAD

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

VAUGHAN PERSONAL CARE BOARDING HOME

17. Father's Name (First, Middle, Last)

SCHANZES A HOLMES

18. Mother's Name (First, Middle, Maiden Surname)

BARBARA J HOLMES

19a. Informant's Name/Relationship (Type, Print)

Nikita West/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

106 Spesutia Rd., Aberdeen, Maryland 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST JAMES AME CHURCH

Date

2-20-99 HARFORD CO., MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Barbara J. Brown

22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME  
1206 W NORTH AVENUE  
PA

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

NA

28b. Time of Injury

NA

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

NA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

NA

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ganesh P. Prahbu MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

FEB 13 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ganesh Prahbu, MD, Harford Memorial Hosp.

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5 RB

Conyers, Michelle Antionette

2-13-99 0249



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State of Maryland / Department of Health and Mental Hygiene

99 04611

Item:31 per vr 2/18/99 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Patrick Connell, Sr.				2. Date of Death Month Day Year February 16, 1999		3. Time of Death 1:00 PM	
	4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore Co.	
Funeral Director	5. Social Security Number 159-05-6443	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) October 11, 1917		9. Birthplace (State or Foreign Country) Philadelphia, Pa.
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Towson			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 930 Breezewick Circle				10f. Zip Code 21286		10g. Citizen of What Country? United States of America		
11. Marital Status 1 <input type="checkbox"/> Navar Marriad 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: W.W.II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 04				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman			16b. Kind of Business/Industry Building Products	
17. Father's Name (First, Middle, Last) Thomas Joseph Connell				18. Mother's Name (First, Middle, Maiden Sumeme) Helen M. Kearns				
19a. Informant's Name/Relationship (Type, Print) Mrs. Susan(nee Connell)Muth (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3215 Berkshire Road Baltimore, Maryland 21214				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery		20c. Location - City or Town, State Yeadon, Pa. (Delaware Co.)		
21. Signature of Funeral Service Licensee Jeffrey L. Gair				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Massive Myocardial Infarction Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 mins years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death: 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Joseph P. Reynolds		29c. License number D-22334		29d. Date signed (Month, Day, Year) Feb. 17, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FEBLEY, Joseph 3901 Greenspring Ave BALTIMORE MD 21211								
31. Date filed (Month, Day, Year) Feb 17 1999		32. Registrar's Signature Berna B. Sparks						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04612  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lena Rose DeLuca

2. Date of Death

Month Day Year  
February 14, 1999

3. Time of Death

4:20 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

215-32-0496

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 20, 1913

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

102 Shipway

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Peter Fortino

18. Mother's Name (First, Middle, Maiden Summa)

Rose Falbo

19a. Informant's Name/Relationship (Type, Print)

Dr. Frank DeLuca / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7952 Starburst Drive, Baltimore, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Stanislaus Cemetery 2/18/1999 Dundalk, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure, but only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic Obstructed Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 18 1999

State  
Registrar

LENA DELUCA February 14, 1999 4:20 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04613

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

OLIVE H ELLIS

2. Date of Death

Month Year  
FEB 16 1999

3. Time of Death

12:02 PM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-05-3101

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 11, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

5538 Ashbourne Road

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Clement Archer

18. Mother's Name (First, Middle, Maiden Surname)

Hanna Tabler

19a. Informant's Name/Relationship (Type, Print)

Donald E. Ellis, Sr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 West End Court Baltimore, Maryland 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 2/19/99 Baltimore, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ambrose Funeral Home, Inc. Arbutus

1328 Sulphur Spring Rd. Arbutus, Md. 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Sepsis (Chasepsis)

Due to (or as a consequence of):

b.

Atrial Fibrillation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Left Renal stone + Hydronephrosis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

One week

? duration

weeks.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] THAW POON, MD

29c. License number

D 51088

29d. Date signed (Month, Day, Year)

FEB 16 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thaw Poon, St. Agnes Hospital, 900 Caton Ave, Baltimore, MD 21209

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

[Signature] B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 23 Part 1abc, 23 Part II Per ME Film G768 2-18-99

Certificate of Death

Reg. No. 99 04614

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

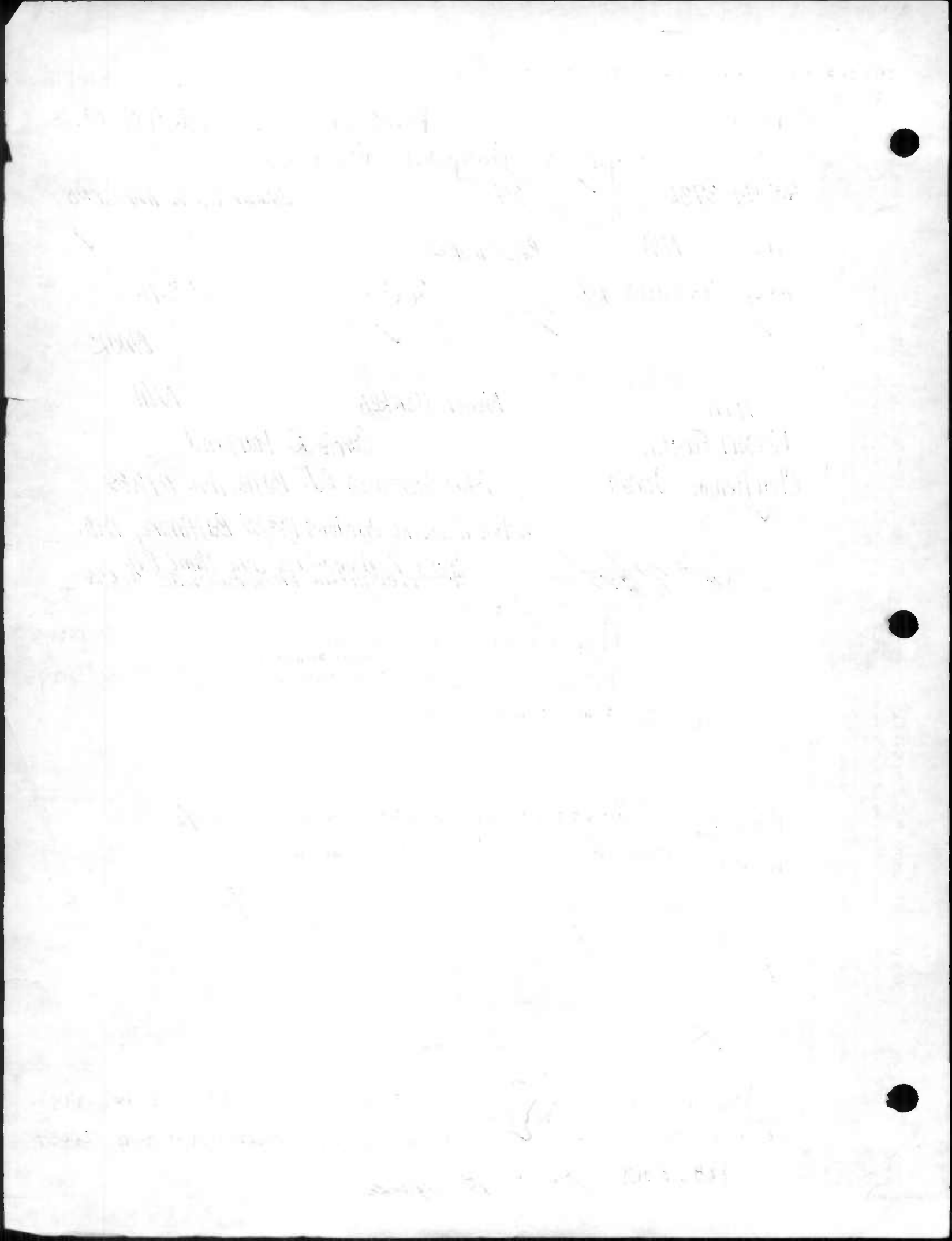
Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Taren Forston</b>		2. Date of Death Month <b>January</b> Day <b>16</b> Year <b>1999</b>		3. Time of Death <b>19:25</b>	
4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
5. Social Security Number <b>215-74-3730</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>37</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>November 29, 1961</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>			
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1404 Stone Wood Rd.</b>		10f. Zip Code <b>21239</b>	
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Never Worked</b>		16b. Kind of Business/Industry <b>N/A</b>	
17. Father's Name (First, Middle, Last) <b>Nelson Forston</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Carrie R. Harland</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Charliemae Jones</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1404 Stonewood Rd. Balto, MD. 21239</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Memorial Gardens</b>		20c. Location - City or Town, State <b>Baltimore, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>GARY R. WARECH FUNERAL HOME P.A. 3910 FREDERICK AVE. BALTO, MD. 21209</b>			
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Aspiration Pneumonia</b> Due to (or as a consequence of): <b>Fulminant Pneumonia</b> <b>Heroin Intoxication</b> Due to (or as a consequence of): <b>Acquired Immunodeficiency Syndrome</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Melissa Turner M.D.</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 16, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MELISSA TURNER JOHNS HOPKINS HOSPITAL BALTIMORE MARYLAND 21287</b>					
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 04615

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT L FISHER

2. Date of Death

Month

Day

Year

FEBRUARY 13 1999

3. Time of Death

15:37

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-44-1029

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

September 21, 1946

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3707 MT. PLESANT AVENUE

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LONGSHOREMAN

16b. Kind of Business/Industry

I.L.A.

17. Fether's Name (First, Middle, Last)

GROVER CLEVELAND FISHER

18. Mother's Name (First, Middle, Maiden Surname)

ETHEL TRACY

19a. Informant's Name/Relationship (Type, Print)

MRS. MICHELE FISHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3707 MT. PLESANT AVE. BALTIMORE, MD. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OAK LAWN CEMETERY 2/17/99

Date

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

Charles Kaczorowski

22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME P.A.

1201 DUNDALK AVE. BALTIMORE, MD. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ISCHEMIC DILATED CARDIOMYOPATHY

Due to (or as a consequence of):

YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE; HISTORY OF MI and CABG

DIABETES MELLITUS

HISTORY OF STROKE; ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lorin Graef, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LORIN GRAEF, MD Johns Hopkins Bayview Medical Center 4940 Eastern Avenue Baltimore, MD 21224

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 10d, e, 15, 16a, b, 20a, b, c, 22 per F.H. G-769 3/2/99 rev

Certificate of Death

Reg. No.

99 04616

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>VIRGINIA GLENN</b>		2. Date of Death Month <b>FEB</b> Day <b>4</b> Year <b>99</b>		3. Time of Death <b>7:26 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>			4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince George's</b>
5. Social Security Number <b>085-30-7461</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 17, 1918</b>
Usual Residence of Decedent			9. Birthplace (State or Foreign Country) <b>North Carolina</b>		
10a. State <b>D.C.</b>	10b. County <b>unknown</b>	10c. City, Town or Location <b>Washington</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>4201 Butterworth Place N.W.</b>		10f. Zip Code <b>20016</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown 4th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unknown Teacher</b>	
16b. Kind of Business/Industry <b>unknown Education</b>		17. Father's Name (First, Middle, Last) <b>unknown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>	
19a. Informant's Name/Relationship (Type, Print) <b>unknown</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unknown</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Quantico Nat'l Cem.</b>		20c. Location - City or Town, State <b>Triangle, Va.</b>	
21. Signature of Funeral Service Licensee <b>Joseph B. Van Sant</b>		22. Name and Address of Facility <b>Joseph Gawler's Sons Wash, D.C.</b> <b>State Anatomy Board 655 W. Baltimore Street</b> <b>Baltimore, Maryland 21201 5130 Wisconsin Ave. N.W.</b>			
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cerebrovascular Accident</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Right Atrial Tachycardia and inter-ventricular Hemorrhage</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier <b>[Signature] M.D.</b>		29c. License number <b>24721</b>		29d. Date signed (Month, Day, Year) <b>2/4/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SYED SADIK, 14333 LAUREL BOWIE RD. LAUREL, MD 20708</b>					
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature <b>[Signature]</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04617

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Tommy Lee Hunter

2. Date of Death

February 17 1999

3. Time of Death

6:15 AM

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

219-78-0320

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

37 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 20, 1961

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10e. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2323 Whittier Avenue

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (14 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Never Worked

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

William M. Hunter

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Brown

19e. Informant's Name/Relationship (Type, Print)

John K. Hunter/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2323 Whittier Avenue Baltimore, MD 21217

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

2/18/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of MD, Inc.  
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multisystem organ Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Terminal human immunodeficiency virus

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Meier, MD

29c. License number

P11828

29d. Date signed (Month, Day, Year)

February 17, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Kasha Morad, M.D. @ Maryland General Hospital

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Tommy Hunter  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04618

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AMALIA IAFOLLA						2. Date of Death Month Day Year February 16, 1999		3. Time of Death 9:16 AM																					
	4a. Facility Name (If not institution, give street and number) Colonial Manor Homes						4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore																					
Funeral Director	5. Social Security Number 231-96-9828		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) 01-16-1913		9. Birthplace (State or Foreign Country) Italy																					
	Usual Residence of Decedent																													
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
10e. Street and Number 6348 Frederick Road						10f. Zip Code 21228		10g. Citizen of What Country? United States																						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White																						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home																								
17. Father's Name (First, Middle, Last) Antonio DiPaolo						18. Mother's Name (First, Middle, Maiden Surname) Maria Not Known																								
19a. Informant's Name/Relationship (Type, Print) Mr. Richard A. Iafolla (Son)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2710 E. Strathmore Avenue Baltimore, Md. 21214																								
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) entombment				20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 2-20-99																						
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214																								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																														
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>MYOCARDIAL INFARCTION</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td>5 minutes</td> </tr> <tr> <td>b.</td> <td>CORONARY ARTERY DISEASE</td> <td>YEARS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	MYOCARDIAL INFARCTION	Approximate Interval Between Onset and Death	Due to (or as a consequence of):		5 minutes	b.	CORONARY ARTERY DISEASE	YEARS	Due to (or as a consequence of):			c.	Due to (or as a consequence of):			d.	Due to (or as a consequence of):		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	MYOCARDIAL INFARCTION	Approximate Interval Between Onset and Death																											
	Due to (or as a consequence of):		5 minutes																											
	b.	CORONARY ARTERY DISEASE	YEARS																											
	Due to (or as a consequence of):																													
c.	Due to (or as a consequence of):																													
d.	Due to (or as a consequence of):																													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS																														
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																														
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																														
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ACUTE LIVING																														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																														
29b. Signature and title of certifier 						29c. License number 127394		29d. Date signed (Month, Day, Year) 2/17/99																						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH NAVEY BLVD #203 BALTO, MD 21239 / JAMES P. RICHARDSON MD																														
31. Date filed (Month, Day, Year) FEB 18 1999		32. Registrar's Signature 																												

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





DANNY

State of Maryland / Department of Health and Mental Hygiene

JOHNSON

ITEMS: #23 PART 1, 27, 28A-F PER MEO G768

2-24-99, WR.  
Certificate of Death

Reg. No.

99 04619

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Danny Lewis Johnson						2. Date of Death Month Day Year FEBRUARY 16, 1999		3. Time of Death 9:29A.M.		
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER						4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 214-17-1310		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		8. Date of Birth (Month, Day, Year) 7-17-1959		9. Birthplace (State or Foreign Country) S. C.		
	Usual Residence of Decedent										
10a. State Md		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 3322 Ripple Road				10f. Zip Code 21244		10g. Citizen of What Country? U S A					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed			16b. Kind of Business/Industry Construction				
17. Father's Name (First, Middle, Last) Arthur Earl Laney						18. Mother's Name (First, Middle, Maiden Surname) Carolyn Johnson					
19a. Informant's Name/Relationship (Type, Print) Donna L. Johnson						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3322 Ripple Road Baltimore, Md 21244					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 2-19-99		20c. Location - City or Town, State Baltimore, Md			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) NARCOTIC INTOXICATION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24e. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) UNKNOWN		28b. Time of Injury UNKNOWN M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
				28d. Describe how injury occurred UNKNOWN		28f. Location (Street and Number or Rural Route Number, City or Town, State) 3322 RIPPLE ROAD.					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found at home							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 17, 1999			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) FEB 18 1999				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

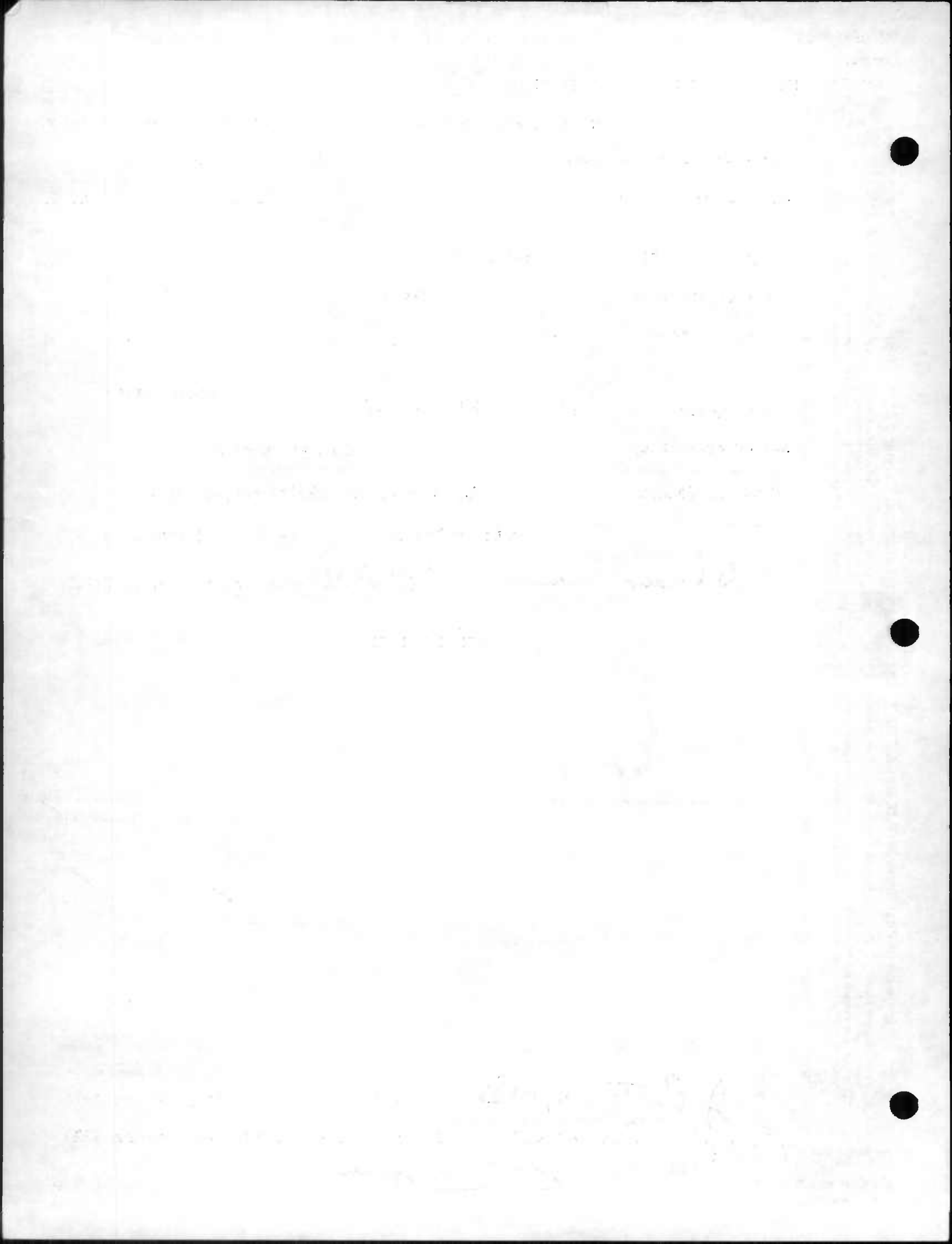
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04620

ITA KRISTBERG  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>ITA KRITSBERG</b>		2. Date of Death Month <b>FEB</b> Day <b>14</b> Year <b>1999</b>		3. Time of Death <b>1108AM</b>	
4a. Facility Name (If not institution, give street and number) <b>LEVINDALE</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
5. Social Security Number <b>218-31-4053</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78 Yrs.</b>	8. Date of Birth (Month, Day, Year) <b>NOV. 16 1920</b>	9. Birthplace (State or Foreign Country) <b>UKRAINE</b>
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2540 W. BELVEDERE AVE.</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TEACHER</b>		16b. Kind of Business/Industry <b>EDUCATION</b>			
17. Father's Name (First, Middle, Last) <b>(UNAVAILABLE)</b>			18. Mother's Name (First, Middle, Maiden Summa) <b>(UNAVAILABLE)</b>		
19a. Informant's Name/Relationship (Type, Print) <b>EMMA LEBEDEV/NIECE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6932 COPPERBEND LANE BALTIMORE MD 21209</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HAR SINAI CONG. CEMETERY</b>		20c. Location - City or Town, State <b>2/16/99 OWINGS MILLS MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ADENOCARCINOMA LIVER - "METASTATIC"</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of):  <b>c. _____</b> Due to (or as a consequence of):  <b>d. _____</b>					Approximate Interval Between Onset and Death <b>SIX WEEKS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>OLD CEREBROVASCULAR ACCIDENT, HYPERTENSION,</b> <b>NON-INSULIN DEPENDENT DIABETES MELLITUS.</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier  <b>ATTENDING PHYSICIAN</b>		29c. License number <b>D 25610</b>		29d. Date signed (Month, Day, Year) <b>FEB. 15. 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SET HTWAR M.D. LEVINDALE 2434 WEST BELVEDERE AVENUE BALTIMORE MD 21215</b>					
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04621

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>GEORGE LUCAS</b>		2. Date of Death Month Day Year <b>February 13 1999</b>		3. Time of Death <b>2:15 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Veterans Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>304-54-4363</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>51</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>AUG. 6, 1947</b>		9. Birthplace (State or Foreign Country) <b>Indiana</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>6951 Hatfield Ct. #208</b>		10f. Zip Code <b>21703</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Store Manager</b>		16b. Kind of Business/Industry <b>Home Improvement</b>	
17. Father's Name (First, Middle, Last) <b>Charles Lucas</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Delores Hemmelmarm</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Connie Lucas - wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6951 Hatfield Ct., #208, Frederick, Md. 21703</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Covington Memorial Grdn.</b>		20c. Location - City or Town, State <b>Ft. Wayne, Indiana</b>	
21. Signature of Funeral Service Licensed		22. Name and Address of Facility <b>Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkrige, Md. 21075</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) e. <b>Endstage Liver Disease</b> Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Nancy Arta</b>		29c. License number <b>P10339</b>		29d. Date signed (Month, Day, Year) <b>February 13, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>NANCY ARTA, Veterans Hospital</b>					
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature <b>B. Sparks</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Division of Vital Records, P.O. Box 68760

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04622

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emily Aniela Makauskas				2. Date of Death Month Day Year FEB. 14, 1999		3. Time of Death 11:45 AM				
	4a. Facility Name (If not institution, give street and number) 806 Hollins Street				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A				
Funeral Director	5. Social Security Number 213-28-1048		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 8, 1922		9. Birthplace (State or Foreign Country) Poland		
	Usual Residence of Decedent										
10a. State MD			10b. County N/A			10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 806 Hollins Street				10f. Zip Code 21201			10g. Citizen of What Country? USA				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lab Research Tech.				16b. Kind of Business/Industry State Employee			
17. Father's Name (First, Middle, Last) Andrew Makauskas						18. Mother's Name (First, Middle, Maiden Surname) Anna Lazaunikas					
19a. Informant's Name/Relationship (Type, Print) Vytautas Makauskas - brother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8028 Woodholme Circle, Pasadena, Md. 21122						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cem.			Date 2/18/99		20c. Location - City or Town, State Baltimore, Md.		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP 7250 Washington Blvd., ElkrIDGE, Md. 21075						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  e. <u>respiratory arrest</u> Due to (or as a consequence of): b. <u>bilateral pleural effusions</u> Due to (or as a consequence of): c. <u>cervical cancer metastasized to lung</u> Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Rebecca Byrd					29c. License number D31320			29d. Date signed (Month, Day, Year) 2-16-99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rebecca Byrd MD White Marsh Medical Center, White Marsh, Md.											
31. Date filed (Month, Day, Year) FEB 18 1999				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 04623

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>WILLET</u>		2. Date of Death Month <u>Feb</u> Day <u>16</u> Year <u>1999</u>		3. Time of Death <u>0830AM</u>
	4a. Facility Name (If not institution, give street and number) <u>Howard County Hospital</u>		4b. City, Town, or Location of Death <u>Columbia</u>		4c. County of Death <u>Howard</u>
Funeral Director	5. Social Security Number <u>493-07-9232</u>	6. Sex <u>M</u> <input type="checkbox"/> <u>F</u> <input type="checkbox"/>	7. Age (In yrs. last birthday) <u>93</u> Yrs.	If Under 1 Year Months <u>  </u> Days <u>  </u>	If Under 24 Hrs. Hours <u>  </u> Min. <u>  </u>
	8. Date of Birth (Month, Day, Year) <u>JAN 14, 1906</u>		9. Birthplace (State or Foreign Country) <u>Kentucky</u>		
Usual Residence of Decedent					
10a. State <u>Maryland</u>		10b. County <u>Howard</u>		10c. City, Town or Location <u>Columbia</u>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <u>5400 Vantage Point Road #114</u>			10f. Zip Code <u>21044</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>White</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>  </u> College (14 or 5+) <u>4</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Chemist</u>		16b. Kind of Business/Industry <u>Automotive</u>	
17. Father's Name (First, Middle, Last) <u>Willett C. Magruder</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Eva W. Liter</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Alice M. Kissel/daughter</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3639 St. John's Lane Ellicott City, MD 21044</u>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory, Inc.</u>		20c. Location - City or Town, State <u>Baltimore, MD</u>	
21. Signature of Funeral Service Licensee <u>Dawn F. McDonald</u>		22. Name and Address of Facility <u>Cremation Society of Maryland, Inc.</u> <u>299 Frederick Road Baltimore, MD 21228</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <u>Renal failure</u>					
Due to (or as a consequence of):					
b. <u>Respiratory failure</u>					
Due to (or as a consequence of):					
c. <u>premature Aortic septum</u>					
Due to (or as a consequence of):					
d. <u>chronic obstructive pulmonary disease</u>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Colon cancer</u>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <u>  </u>		28b. Time of Injury <u>  </u> M <u>  </u>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D-34868</u>		29d. Date signed (Month, Day, Year) <u>Feb 16, 1999</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dawn F. McDonald</u> <u>1101 Little Robert Parkway Columbia, MD 21044</u>					
31. Date filed (Month, Day, Year) <u>FEB 18 1999</u>		32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04624

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ivy L. Morris</b>				2. Date of Death Month Day Year <b>February 16 1999</b>		3. Time of Death <b>07:58 p</b>	
	4a. Facility Name (If no institution, give street and number) <b>Sinai Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>218-64-1214</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>46</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 1 1952</b>	
	9. Birthplace (State or Foreign Country) <b>N.C.</b>		10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4117 Fairview Ave.</b>		10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse's Assistant</b>		16b. Kind of Business/Industry <b>Medical</b>				
17. Father's Name (First, Middle, Last) <b>Jimmie Morris</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Miller</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Shirley Acosta / SISTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4106 W. Forest Park Ave. Balto, MD 21207</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn</b>		20c. Location - City or Town, State <b>2-20-99 Balto., MD.</b>				
21. Signature of Funeral Service Licensee <b>James A. Morton</b>				22. Name and Address of Facility <b>James A. Morton &amp; Sons 1701 Laurens St. Balto., Md. 21217</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>pneumonia</b> Due to (or as a consequence of): b. <b>AIDS</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Eddie Bullock MD</b>				29c. License number <b>P12308</b>		29d. Date signed (Month, Day, Year) <b>February 16 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Eddie Bullock 2401 West Belvedere Avenue Baltimore MD 21215</b>								
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature <b>Beverly B. Sparks</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

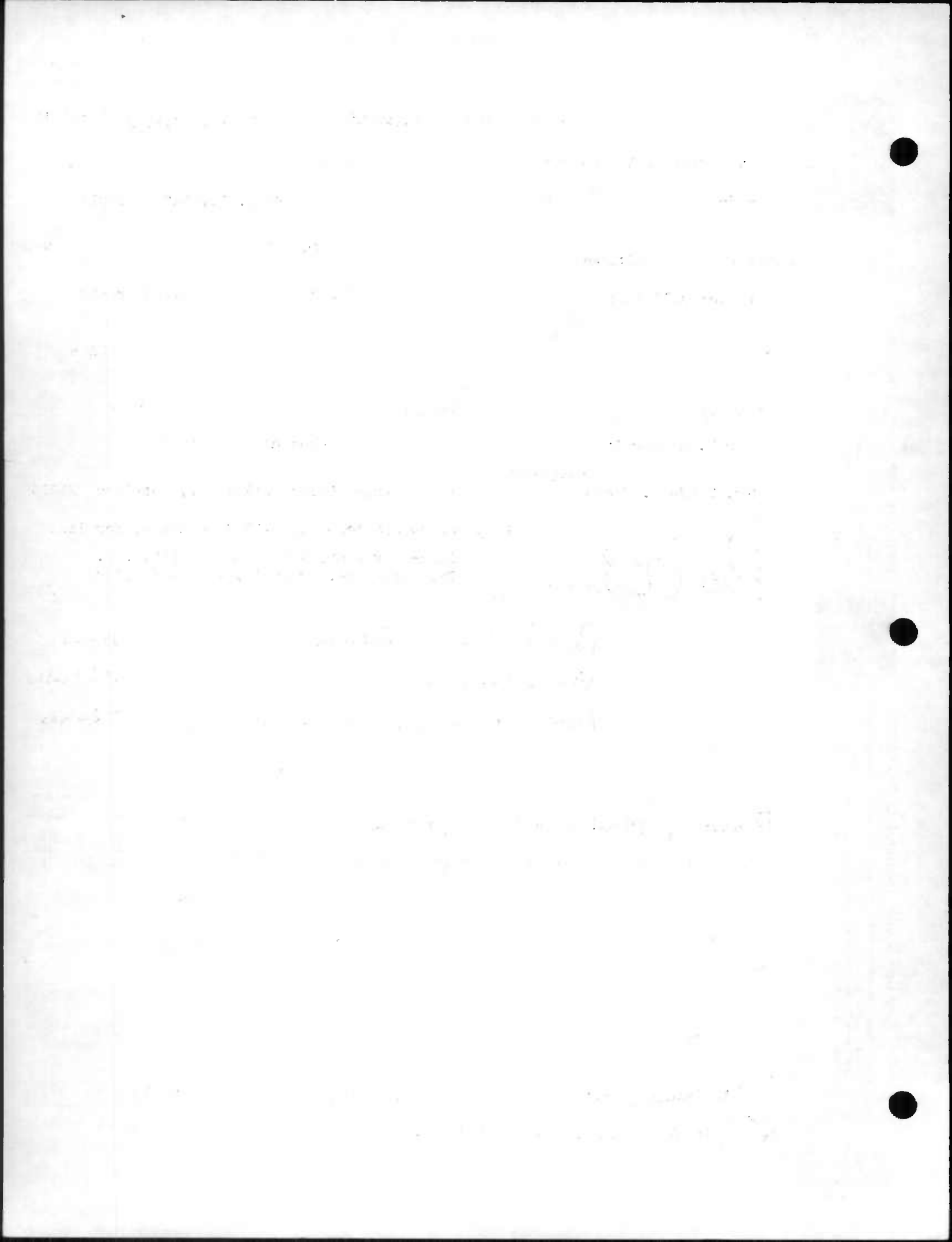
99 04625

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Agatha Mary Majewski				2. Date of Death Month Day Year February 13, 1999		3. Time of Death 11:51 AM	
	4a. Facility Name (If not institution, give street and number) Manor Care Health Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore Co.	
Funeral Director	5. Social Security Number 220-24-9488		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 18, 1929	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1905 Larkhall Road		10f. Zip Code 21222		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) John F. Blachowicz				18. Mother's Name (First, Middle, Maiden Surname) Michalena Sarnieki			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Linda J. Kazlo Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10129 Fontaine Drive Baltimore, Maryland 21234			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary Cemetery		20c. Location - City or Town, State Dundalk, Maryland		20d. Date 2/16/1999	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Progressive Pulmonary Embolism</i> Due to (or as a consequence of): <i>VENOUS THROMBOSIS</i> Due to (or as a consequence of): <i>Arteriosclerotic Vascular Disease</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Diabetes, Atrial Fibrillation, Chronic Congestive heart failure, Hypertension</i>				Approximate Interval Between Onset and Death <i>Minutes</i> <i>&gt; 3 months</i> <i>&gt; 20 yrs</i>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes, Atrial Fibrillation, Chronic Congestive heart failure, Hypertension</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
To Be Completed by Physician/Medical Examiner	29c. Signature and title of certifier <i>[Signature]</i>		29d. License number D36430		29e. Date signed (Month, Day, Year) 2/15/99			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY M. RICHMOND MD 7112 Dundalk Ave. Baltimore MD 21222							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) FEB 18 1999		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04626

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE MILLER

2. Date of Death

Month Day Year  
FEBRUARY 3 1999

3. Time of Death

11 35 AM

4a. Facility Name (If not institution, give street and number)

NORTH WEST HOSPITAL

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

219-18-6662

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Sept. 24, 1925

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County-Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5412 Old Court Road

10f. Zip Code

21133

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

George Miller

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph E. Van Sant

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. COPD

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

C. Ravi MD

29c. License number

D37333

29d. Date signed (Month, Day, Year)

FEBRUARY 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. RAVI MD, MHC, BALTO. MD 21133

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

James B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04627

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH J. NOWAKOWSKI</b>				2. Date of Death Month <b>FEBRUARY</b> Day <b>12</b> Year <b>1999</b>		3. Time of Death <b>12:41</b>	
	4a. Facility Name (If not institution, give street and number) <b>CHURCH HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-03-7504</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>2/27/14</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>603 S. DECKER AVENUE</b>			10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SCHOOL MAINTENANCE</b>			16b. Kind of Business/Industry <b>BALTIMORE CITY</b>		
	17. Father's Name (First, Middle, Last) <b>STEFAN NOWAKOWSKI</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>FELIKSA KALENDEK</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>MR. ROBERT NOWAKOWSKI</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12170 MT. ALBERT RD. ELLICOTT CITY, MD. 21042</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. STANISLAUS CEME.</b>		Date <b>2/16/99</b>	20c. Location - City or Town, State <b>BALTIMORE, MD.</b>		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTIMORE, MD. 21224</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>b. SUSPECTED CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b> <b>HYPERLIPIDEMIA</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D15530</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 12, 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>BAYANI B. ELMA, MD 3023 EASTERN AVENUE BALTIMORE, MD. 21224</b>								
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04628

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Russell Parrish</i>				2. Date of Death Month <i>2</i> Day <i>11</i> Year <i>99</i>		3. Time of Death <i>6:00 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>3 Peachtree Court</i>				4b. City, Town, or Location of Death <i>Pikesville</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>219-12-6755</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>74</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>4-29-24</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>MD.</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>2301 Southern Avenue</i>				10f. Zip Code <i>21214</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4or 5+) <i>N/A</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Longshoreman</i>		16b. Kind of Business/Industry <i>Steamship Trade</i>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>George Parrish</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Jeannette Robinson</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Janeen Parrish McLean Daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3 Peachtree Court, Pikesville MD, 21208</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Cedar Hill</i>		20c. Location - City or Town, State <i>2/15/99 Glen Burnie, MD</i>			
	21. Signature of Funeral Service Licensee <i>Hari P. Ch...</i>				22. Name and Address of Facility <i>Hari P. Chong Funeral Service 1701 McCulloch St, Baltimore, MD 21217</i>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Metastatic Prostate Cancer</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. ...</i> Due to (or as a consequence of): <i>c. ...</i> Due to (or as a consequence of): <i>d. ...</i>							Approximate Interval Between Onset and Death <i>7 years</i>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Anemic 2° to prostate CA</i> <i>Proximal myopathy 2° to prostate CA</i>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Daughter's home</i>							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>Dana Frank</i>				29c. License number <i>026003</i>		29d. Date signed (Month, Day, Year) <i>2-18-99</i>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dana Frank MD 10755 Falls Road Suite 200 Lutherville, MD 21093</i>							
	31. Date filed (Month, Day, Year) <i>FEB 18 1999</i>				32. Registrar's Signature <i>Benita B. Sparks</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

99 04629

Item#19a perFHG768 2/18/99 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHIRLEE H. PERLMAN				2. Date of Death Month Day Year 2 15 99		3. Time of Death 12:45 PM						
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL				4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death BALTIMORE						
Funeral Director	5. Social Security Number 216-20-5062		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) 8 25 1926						
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location OWINGS MILLS						
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	10e. Street and Number ONE HIAWATHA COURT APT 1M				10f. Zip Code 21117		10g. Citizen of What Country? U.S.A.						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CASHIER		16b. Kind of Business/Industry RESTAURANT								
	17. Father's Name (First, Middle, Last) BENJAMIN FRIEDLANDER				18. Mother's Name (First, Middle, Maiden Surname) LEAH FRIEDLANDER								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) BUNNY COHEN/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8516 GREEN LANE BALTIMORE MD 21244								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HEBREW ORTHODOX MEMORIAL SOCIETY		Date 2/16/99		20c. Location - City or Town, State BALTIMORE MD						
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. SEPSIS</td> <td rowspan="4">Approximate Interval Between Onset and Death 24 hours</td> </tr> <tr> <td>b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 15 years</td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	Approximate Interval Between Onset and Death 24 hours	b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 15 years	c.
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	Approximate Interval Between Onset and Death 24 hours											
	b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 15 years												
	c.												
	d.												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier Ly Mathew MD				29c. License number DS0164		29d. Date signed (Month, Day, Year) 2/15/99							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lizi Mathew MD Northwest Hospital													
31. Date filed (Month, Day, Year) FEB 18 1999				32. Registrar's Signature Benita B. Sparks									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04630

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Samuel M. Peacock Jr.</b>				2. Date of Death Month <b>February</b> Day <b>16</b> Year <b>1999</b>		3. Time of Death <b>16:40</b>	
4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>213-07-7252</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>95</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 7, 1903</b>	
9. Birthplace (State or Foreign Country) <b>Baltimore Md.</b>							
Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore City</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>6308 Moyer Avenue</b>				10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Beth. Steel</b>	
17. Father's Name (First, Middle, Last) <b>Samuel M. Peacock Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary E. Smith</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Samuel M. Peacock III (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6306 Moyer Avenue Baltimore, Maryland 21206</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		Date <b>2/19/99</b>		20c. Location - City or Town, State <b>Baltimore Maryland</b>	
21. Signature of Funeral Service Licensee <b>Milton J Knight Jr</b> 				22. Name and Address of Facility <b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214</b>			
23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>							
Approximate Interval Between Onset and Death <b>2 weeks</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b> <b>Urinary Tract Infection</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>AT2438946C12</b>		29d. Date signed (Month, Day, Year) <b>February 16, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>201 East University Parkway, Baltimore, MD 21218</b>							
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04631

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MATTHEW H ROBINSON</b>				2. Date of Death Month <b>FEB</b> Day <b>15</b> Year <b>99</b>		3. Time of Death <b>5:45p</b>			
	4a. Facility Name (If not institution, give street and number) <b>BALTIMORE VA MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>229-20-8157</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>07/25/1928</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>4503 NORFOLK AVENUE</b>			10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Chief Custodian</b>		16b. Kind of Business/Industry <b>Board of Education</b>					
	17. Father's Name (First, Middle, Last) <b>Wellington Robinson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ada Thornton</b>					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mary L. Robinson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4503 Norfolk Avenue, Baltimore, MD 21216</b>					
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet. Cem.</b>		20c. Location - City or Town, State <b>Owings Mills, MD</b>					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>LEROY O. DYETT &amp; SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD 21207</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. TRANSITIONAL COL BLADDER CANCER</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>							Approximate Interval Between Onset and Death		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)							
	27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how Injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>211771</b>		29d. Date signed (Month, Day, Year) <b>2/15/99</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>THOMAS HAGUEN, MD 10 N. GREENE ST, BALTIMORE, MD 21201</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Ietm#17 perFHG768 2/18/99 EW

Reg. No.

99 04632

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cora Catherine Rodgers

2. Date of Death

Month 2 Day 13 Year 1999

3. Time of Death

8:00a.m.

4a. Facility Name (If not institution, give street and number)

Lorien N/H Frankford

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

225-36-1340

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 09 29 30

9. Birthplace (State or Foreign Country)

V.A.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1325 East Northern Parkway

10f. Zip Code

21239

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th grade

College (1-4 or 5+)  
na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

O.R. Technician

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Henry Tucker  
Henry Tuclar Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Harrell

19a. Informant's Name/Relationship (Type, Print)

Yvonne Martin-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1325 East Northern Parkway, Balto Md 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery 2/19/99 Baltimore, Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Gene A. Thompson*

22. Name and Address of Facility

March F/H West  
4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic brain Carcinoma 1YR

Due to (or as a consequence of):

b. Hypertension 2YR 8.

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*E. O. O'Leary*

29c. License number

D30641

29d. Date signed (Month, Day, Year)

February 16<sup>th</sup> 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ramern Sabapathi Suite 308 821 N. Eotaw St Baltimore MD 21201

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

*Benjamin B. Sparks*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04633

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>Inez Royster</i>		2. Date of Death Month <i>2</i> Day <i>17</i> Year <i>1999</i>		3. Time of Death <i>0225</i>	
4a. Facility Name (If not Institution, give street and number) <i>Randallstown Nursing Home</i>			4b. City, Town, or Location of Death <i>Randallstown</i>		4c. County of Death <i>Baltimore</i>
5. Social Security Number <i>229-28-5565</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>93</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <i>9-25-1905</i>					
9. Birthplace (State or Foreign Country) <i>Va</i>					
Usual Residence of Decedent					
10a. State <i>Md</i>		10b. County <i>NA</i>		10c. City, Town or Location <i>Baltimore</i>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <i>4321 Kennison Avenue</i>			10f. Zip Code <i>21215</i>		10g. Citizen of What Country? <i>U. S. A</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4or 5+) <i>NA</i>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Laborer</i>		16b. Kind of Business/Industry <i>Laundry</i>			
17. Father's Name (First, Middle, Last) <i>William Carrington</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Martha Ann Beard</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Magruda Pitts - Daughter</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4321 Kennison Avenue Baltimore, Md 21215</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Memorial Park</i>		20c. Location - City or Town, State <i>2-20-99 Arbutus, Md</i>	
21. Signature of Funeral Service Licensee <i>Bladys Warner</i>		22. Name and Address of Facility <i>March F. H. West 4300 Unkash Avenue Baltimore, Md 21215</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <i>Arteriosclerotic cardiovascular disease</i> Due to (or as a consequence of): b. <i>Ischemic cardiomyopathy</i> Due to (or as a consequence of): c. <i>Cerebrovascular Accident</i> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <i>YRS</i> <i>YRS</i> <i>YRS</i>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Kevin M. [Signature]</i>		29c. License number <i>D20333</i>		29d. Date signed (Month, Day, Year) <i>2/17/99</i>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>R. ZONES MD 1838 GREENHURST RD PICESVILLE MD</i>					
31. Date filed (Month, Day, Year) <i>FEB 18 1999</i>		32. Registrar's Signature <i>[Signature]</i>			









Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04635

Levi Roane  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>LEVI ROANE</b>		2. Date of Death Month Day Year <b>February 13, 1999</b>		3. Time of Death <b>4:40 p.m.</b>	
4a. Facility Name (If not institution, give street and number) <b>Maryland General Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>223-28-8860</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>AUG 22 25</b>		9. Birthplace (State or Foreign) <b>VIRGINIA</b>			
Usual Residence of Decedent					
10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>2700 N CHARLES STREET</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>53/55</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. Decedent's Education (Specify only highest grade completed) <b>10th grade</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CEMENT FINISHER</b>		16b. Kind of Business/Industry <b>SAW MILL</b>	
17. Father's Name (First, Middle, Last) <b>RICHARD ROANE</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MOLLY ROANE</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Lottie Roane/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Hcr Box 418, Deltaville, Va 23043</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST</b>		20c. Date <b>2-22</b>	
20d. Location - City or Town, State <b>OWINGS MILLS, MD</b>					
21. Signature of Funeral Service Licensee <i>Barbara Brown</i>		22. Name and Address of Facility <b>WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Septicemia</b> Due to (or as a consequence of): b. <b>Pneumonia</b> Due to (or as a consequence of): c. <b>Advanced end-stage renal disease</b> Due to (or as a consequence of): d.					
23b. Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Ana Sarante</i>		29c. License number <b>P 11908</b>		29d. Date signed (Month, Day, Year) <b>2/13/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ana Sarante, MD c/o Maryland General Hospital</b>					
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature <i>P. Spate</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04636

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Funeral  
Director

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Judson Spears</b>		2. Date of Death Month Day Year <b>FEB. 15, 1999</b>		3. Time of Death <b>11:59 AM.</b>			
4a. Facility Name (If not institution, give street and number) <b>3405 W. NORTHERN PARKWAY</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>			
5. Social Security Number <b>258-01-5387</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.			
8. Date of Birth (Month, Day, Year) <b>FEB 6, 1908</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>					
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
10e. Street and Number <b>3405 W. Northern Parkway</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Factory Worker</b>		16b. Kind of Business/Industry <b>Bendix</b>			
17. Father's Name (First, Middle, Last) <b>Judson Spears</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ella Joyner</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Judy Rukert/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>325 Limestone Valley Dr. Apt. F Cockeysville, MD 21030</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. Location - City or Town, State <b>02/17/99 Baltimore, MD</b>			
21. Signature of Funeral Service Licensee <b>Edward A. Gregochik</b>		22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>						Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <b>INSPECTION</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>			
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>J. Pestaner, M.D.</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>FEB. 16, 1999</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JOSEPH PESTANER M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature <b>Bruce B. Sparks</b>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

99 04637

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Bruce Schaefer				2. Date of Death Month Day Year February 14, 1999		3. Time of Death 9:48 P.M.			
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 216-20-7640		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 13, 1926	9. Birthplace (State or Foreign Country) Baltimore, Maryland		
	Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 8800 Walther Blvd. Apt.#1127				10f. Zip Code 21234		10g. Citizen of What Country? United States of America				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: W.W.II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 04				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plant Manager			16b. Kind of Business/Industry Telecommunications Western Electric			
17. Father's Name (First, Middle, Last) William Schaefer				18. Mother's Name (First, Middle, Maiden Surname) Frances Lavicka						
19a. Informant's Name/Relationship (Type, Print) Donna J. Schaefer (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 East Ostend Street Baltimore, Maryland 21230						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens		Date 02/20/99		20c. Location - City or Town, State Timonium, Maryland		
21. Signature of Funeral Service Licensee Jeffrey L. Gair				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.								Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 2/14/99		28b. Time of Injury 2:20 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Roadway				28d. Describe how injury occurred Subject driving vehicle struck fixed object and vehicle rolled over. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Walther Boulevard + Kuntze Drive Baltimore County						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Theodore M. King				29c. License number O.C.M.E.		
29d. Date signed (Month, Day, Year) February 15, 1999				29e. Name and address of person who completed cause of death (Item 23e) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201				31. Date filed (Month, Day, Year) FEB 18 1999					32. Registrar's Signature B. Sparks	

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04638

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elaine Dorothy Sehnert

2. Date of Death  
Month Day Year

FEBRUARY 15 1999

3. Time of Death  
10:25AM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

488-22-4848

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

8. Date of Birth (Month, Day, Year)

Nov 6, 1924

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

607 West Lake Avenue

10f. Zip Code

21210

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George C. Williams

18. Mother's Name (First, Middle, Maiden Surname)

A. Dorothy Brown

19a. Informant's Name/Relationship (Type, Print)

Dale William Sehnert (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

607 West Lake Avenue, Baltimore, Maryland 21210

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Cemetery

Date

2/17/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*A. Alan Seitz, Jr.*

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home  
3818 Roland Avenue, Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Respiratory Failure*  
Due to (or as a consequence of):

b. *COPD*  
Due to (or as a consequence of):

c. *Pneumonia*  
Due to (or as a consequence of):

d. *Lung Cancer*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*M. Schumacher*

29c. License number

0-44728

29d. Date signed (Month, Day, Year)

2/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6569 North Charles Street Baltimore MD 21204

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

*Beverly B. Sparks*

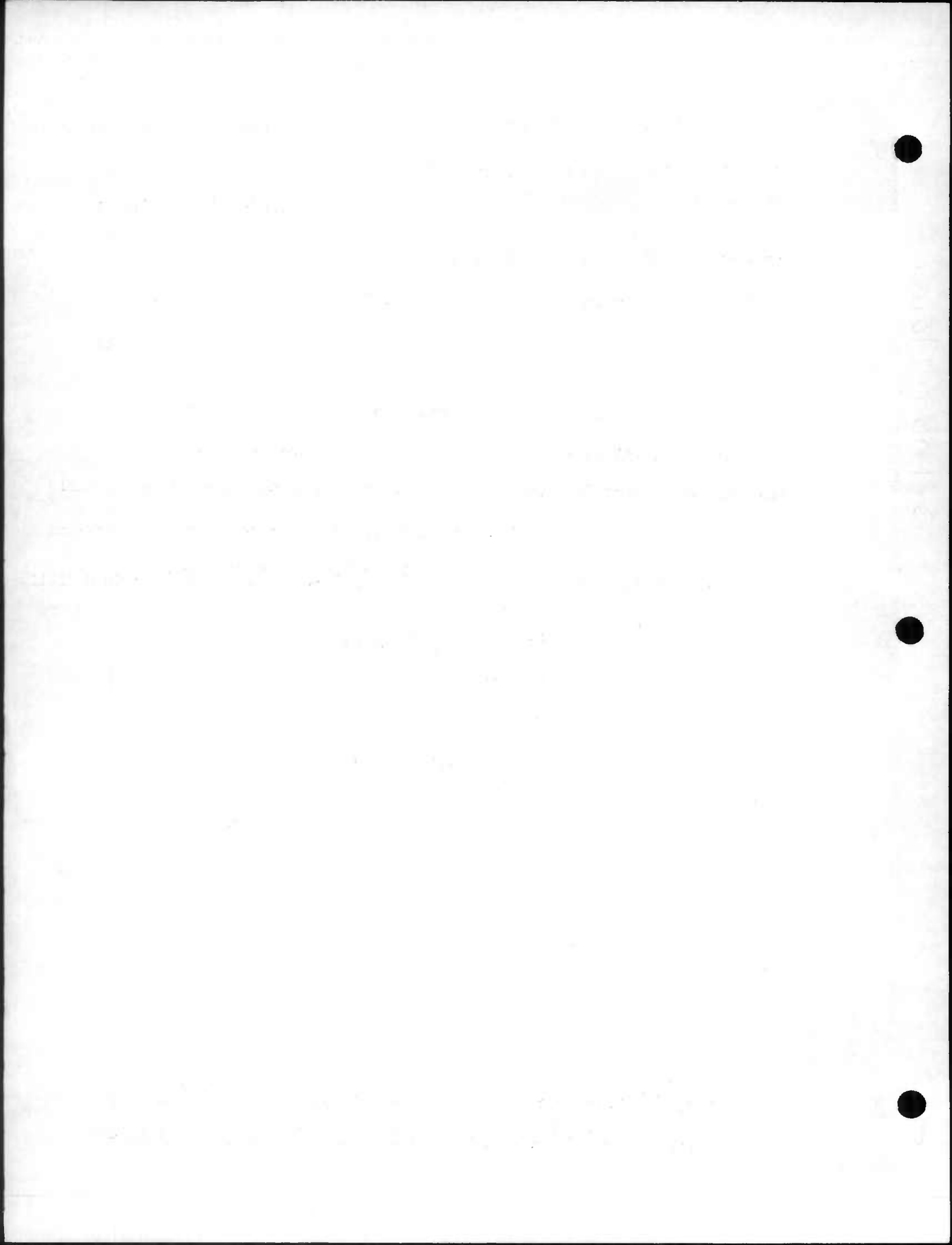
State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Sehnert, Elaine  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04639

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Karen Spencer

2. Date of Death

February 17, 1999

3. Time of Death

10:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3005 Westwood Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

219-07-9247

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 11, 1959

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State  
MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3005 Westwood Avenue

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

NA

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

none

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

Jerome Spencer

18. Mother's Name (First, Middle, Maiden Surname)

Mittie Hayes

19a. Informant's Name/Relationship (Type, Print)

Beverly Gaines (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

200 S. Herring St. Baltimore, MD 21231

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrison Forest

Date

2/23/99 Cwings Mills, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Albert P. Wyllie Funeral Home AA  
638 N. Belmor St. Baltimore, MD 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Metastatic Breast Cancer.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure Disorder.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. P. Sparks

29c. License number

D18320

29d. Date signed (Month, Day, Year)

2/17/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John Hopkins MD Johns Hopkins Oncology Center Baltimore MD 21287

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

Beverly S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

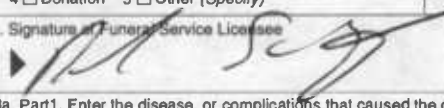
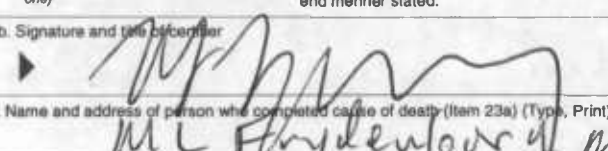
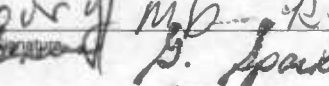




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 04640**  
**Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SIDNEE S. SCHWARTZ</b>					2. Date of Death Month <b>February</b> Day <b>15</b> Year <b>1999</b>			3. Time of Death <b>1415</b>	
	4e. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL</b>					4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-09-7469</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth <b>SEPT. 21 1909</b>		9. Birthplace (State or Foreign) <b>MARYLAND</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>2500 W. BELVEDERE AVE. APT 1020</b>					10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U. S. A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>			16b. Kind of Business/Industry <b>VENDING MACHINES</b>		
17. Father's Name (First, Middle, Last) <b>FRANK SCHWARTZ</b>					18. Mother's Name (First, Middle, Maiden Sumame) <b>CELIA WISE</b>					
19a. Informant's Name/Relationship (Type, Print) <b>JANE WOHL/SISTER</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8019 VALLEY MANOR ROAD OWINGS MILLS MD 21117</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>HEBREW YOUNG MEN'S CEMETERY</b>			Date <b>2/17/99</b>		20c. Location - City or Town, State <b>WOODLAWN MD</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>45 years</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  _____								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number <b>027315</b>			29d. Date signed (Month, Day, Year) <b>February 15, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. L. Hydenburg MD RD #3 Box 304 STEWARTSTOWN PA. 17363</b>										
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b> Registrar's Signature 										

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04641

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALBERT A SCHEIR				2. Date of Death FEB. 14 1999		3. Time of Death 11:50PM		
	4a. Facility Name (If not institution, give street and number) CHERRYWOOD MANOR NURSING HOME				4b. City, Town, or Location of Death REISTERSTOWN		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 217-01-0238		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth NOV 13 1902		
	9. Birthplace (State or Foreign Country) RUSSIA		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2432 FOREST GREEN ROAD		10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES		16b. Kind of Business/Industry MENS CLOTHING					
17. Father's Name (First, Middle, Last) JULIUS SCHEIR				18. Mother's Name (First, Middle, Maiden Surname) SARAH SCHILLER					
19a. Informant's Name/Relationship (Type, Print) EDA RUBIN/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4001 OLD COURT ROAD APT. 213 BALTIMORE MD 21208					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) HEBREW YOUNG MEN CEMETERY		20c. Location - City or Town, State 2/17/99 WOODLAWN MD					
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility SOL LEVINSON & bros. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia</u>								Approximate Interval Between Onset and Death <u>3 days</u>	
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D27031		29d. Date signed (Month, Day, Year) February 15 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lia H Copeland 5310 Old Court Road Randallstown MD 21133									
31. Date filed (Month, Day, Year) FEB 18 1999		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



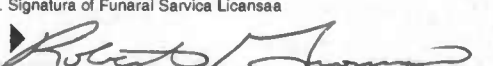
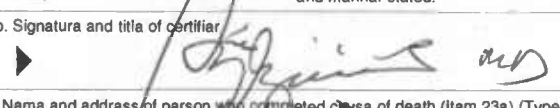
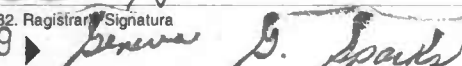
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04642

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BESS SELETZKY</b>				2. Date of Death Month <b>FEBRUARY</b> Day <b>14</b> Year <b>1999</b>		3. Time of Death <b>6:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-46-1328</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN. 11 1906</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PIKESVILLE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. Street and Number <b>16 OLD COURT ROAD APT. 616</b>				10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>HARRY TROTZKY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>FANNIE TROTZKY</b>				
19a. Informant's Name/Relationship (Type, Print) <b>JUDY WEINER/DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>45 FARMHOUSE COURT BALTIMORE MD. 21208</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARLINGTON CEMETERY-CHIZUK AMUNO CONG. CEMETERY</b>		Date <b>2/16/99</b>		20c. Location - City or Town, State <b>BALTIMORE MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Congestive Heart Failure</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arterial Fibrillation</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>244007</b>		29d. Date signed (Month, Day, Year) <b>February 14, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A. J. Thompson, Jr. NW He.</b>								
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04643

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUTH SIMON</b>		2. Date of Death Month <b>FEB.</b> Day <b>12</b> Year <b>1999</b>		3. Time of Death <b>9PM</b>
	4a. Facility Name (If not institution, give street and number) <b>GENESIS ELDERCARE</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>288-18-7527</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month <b>OCT</b> Day <b>23</b> Year <b>1921</b>		9. Birthplace (State or Foreign) <b>OHIO</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10e. Street and Number <b>53 CEDARWOOD CIRCLE</b>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>		16b. Kind of Business/Industry <b>INSURANCE</b>	
17. Father's Name (First, Middle, Last) <b>ABRAHAM OSKOWSKI</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>KATIE BOOKSPAN</b>		
19a. Informant's Name/Relationship (Type, Print) <b>SUSAN MARKS/DAUGHTER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>53 CEDARWOOD CIRCLE BALTIMORE MD 21208</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. OLIVE CEMETERY</b>		20c. Location - City or Town, State <b>2/16/99 CLEVELAND OHIO</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Congestive heart failure</i> Due to (or as a consequence of):</p> <p>b. <i>ischemic cardiomyopathy</i> Due to (or as a consequence of):</p> <p>c.  Due to (or as a consequence of):</p> <p>d.  Due to (or as a consequence of):</p>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>chronic renal failure</i>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D29403</b>		29d. Date signed (Month, Day, Year) <b>February 13, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Cynthia M. Lipsitz MD 1447 York Rd. Lutherville MD 21093</b>					
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23b or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Ryer Schomburg

2. Date of Death

February 8 1999 5:15 P.M.

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

466-90-5700

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 3, 1943

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7864 Cheverly Lane

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
unknown

College (1-4 or 5+)  
unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

Richard Conrad Dutson Ryer

18. Mother's Name (First, Middle, Maiden Surname)

Laurie Hayward

19a. Informant's Name/Relationship (Type, Print)

Lee Waoks/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Argeton MD

29c. License number

D43977

29d. Date signed (Month, Day, Year)

February 8 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Argeton Dutson Ryer, 301 Hospital Drive, Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

Argeton B. Van Sant

State  
Registrar

SHIRLEY SCHOMBURG  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04645

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Rose Pia Thompson

2. Date of Death

Month Day Year  
FEB 16, 1999

3. Time of Death

6:58pm

4a. Facility Name (If not Institution, give street and number)

St. Agnes Nursing and Rehab. Center

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

5. Social Security Number

215-07-5178

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 10, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1 N. Belle Grove Road

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Seamstress

18b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

Hibibb Panza

18. Mother's Name (First, Middle, Maiden Surname)

Gulnina Fioii

19a. Informant's Name/Relationship (Type, Print)

Sandra D. Gladden/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6758 Ducketts Lane Elkridge, MD 21075

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Mem. Park 02/19/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

MacNabb Funeral Home, P.A.

301 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Arterial artery Disease*

Due to (or as a consequence of):

b. *Hypertension*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Ventricular Thrombus**Myocardial Brain Syndrome**Sick Sinus Syndrome*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alejandro Mejia

29c. License number

D08780

29d. Date signed (Month, Day, Year)

Feb 17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALEXANDRO MEJIA

21228  
405 Frederick Rd. Suite 100 Catonsville, MD

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

Geneva S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04646

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NORMA THEAT</b>				2. Date of Death Month Day Year <b>FEBRUARY 16, 1999</b>				3. Time of Death <b>10:12 AM</b>						
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>				4c. County of Death <b>BALTIMORE</b>						
Funeral Director	5. Social Security Number <b>102-34-0308</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>55</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>05 02 43</b>		9. Birthplace (State or Foreign Country) <b>M.D.</b>		
	Usual Residence of Decedent														
10a. State <b>MD</b>		10b. County <b>Baltimore Co.</b>		10c. City, Town or Location <b>Pikesville</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>4705 Three Oaks Road</b>				10f. Zip Code <b>21208</b>				10g. Citizen of What Country? <b>U.S.A.</b>							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>na</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Investigator</b>				16b. Kind of Business/Industry <b>Northern Intelligence Agency</b>							
17. Father's Name (First, Middle, Last) <b>Norman Anders</b>								18. Mother's Name (First, Middle, Maiden Surname) <b>Rosa Lee Day</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Matthew Allen-Stepfather</b>								19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4014 Belle Ave, Baltimore Md 21215</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>				Date <b>2/22/99</b>		20c. Location - City or Town, State <b>Glen Burnie, MD</b>					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>March F/H West</b> <b>4300 wabash Ave, Baltimroe Md 21215</b>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>b. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>c. DIABETES MELLITUS</b> Due to (or as a consequence of): <b>d.</b>														Approximate Interval Between Onset and Death <b>1 HOUR</b> <b>YEARS</b> <b>YEARS</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier 				29c. License number <b>DY7587</b>				29d. Date signed (Month, Day, Year) <b>FEBRUARY 16, 1999</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT FIVE MD 5401 OLD COUNTRY RD RANDALLSTOWN, MD 21133</b>															
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>				32. Registrar's Signature 											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-04647

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Robert Patrick Tracy

2. Date of Death

Month Day Year  
FEBRUARY 15, 1999

3. Time of Death

4:20 PM

4a. Facility Name (If not institution, give street and number)

VA MHCS FORT HOWARD DIVISION

4b. City, Town, or Location of Death

FORT HOWARD

4c. County of Death

BALTIMORE

5. Social Security Number

206-28-6647

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 10, 1932

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1006 Beaglin Park Drive #201

10f. Zip Code

21804

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1956-76

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lieutenant Colonel

16b. Kind of Business/Industry

Military

17. Father's Name (First, Middle, Last)

Sylvester J. Tracy

18. Mother's Name (First, Middle, Maiden Surname)

Mary Margaret English

19a. Informant's Name/Relationship (Type, Print)

Mrs. Joyce Tracy / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2222 Mohegan Drive #204 Falls Church, VA 22043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp. 2/17/1999

Date

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CANCER, LUNG with METASTASIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 1/2 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CANCER OF LARYNX, CHRONIC OBSTRUCTIVE LUNG DISEASE,

HYPOTHYROIDISM, S/P LARYNGECTOMY, S/P RADIATION

TREATMENT.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

34359 (OHIO)

29d. Date signed (Month, Day, Year)

4/10/1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOHN S. LAH, MD 9600 NORTH POINT ROAD FORT HOWARD, MD 21052

State  
Registrar

31. Date filed (Month, Day, Year)

APR 12 1999

32. Registrar's Signature

AKS: ROBERT PATRICK TRACY

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perm. it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

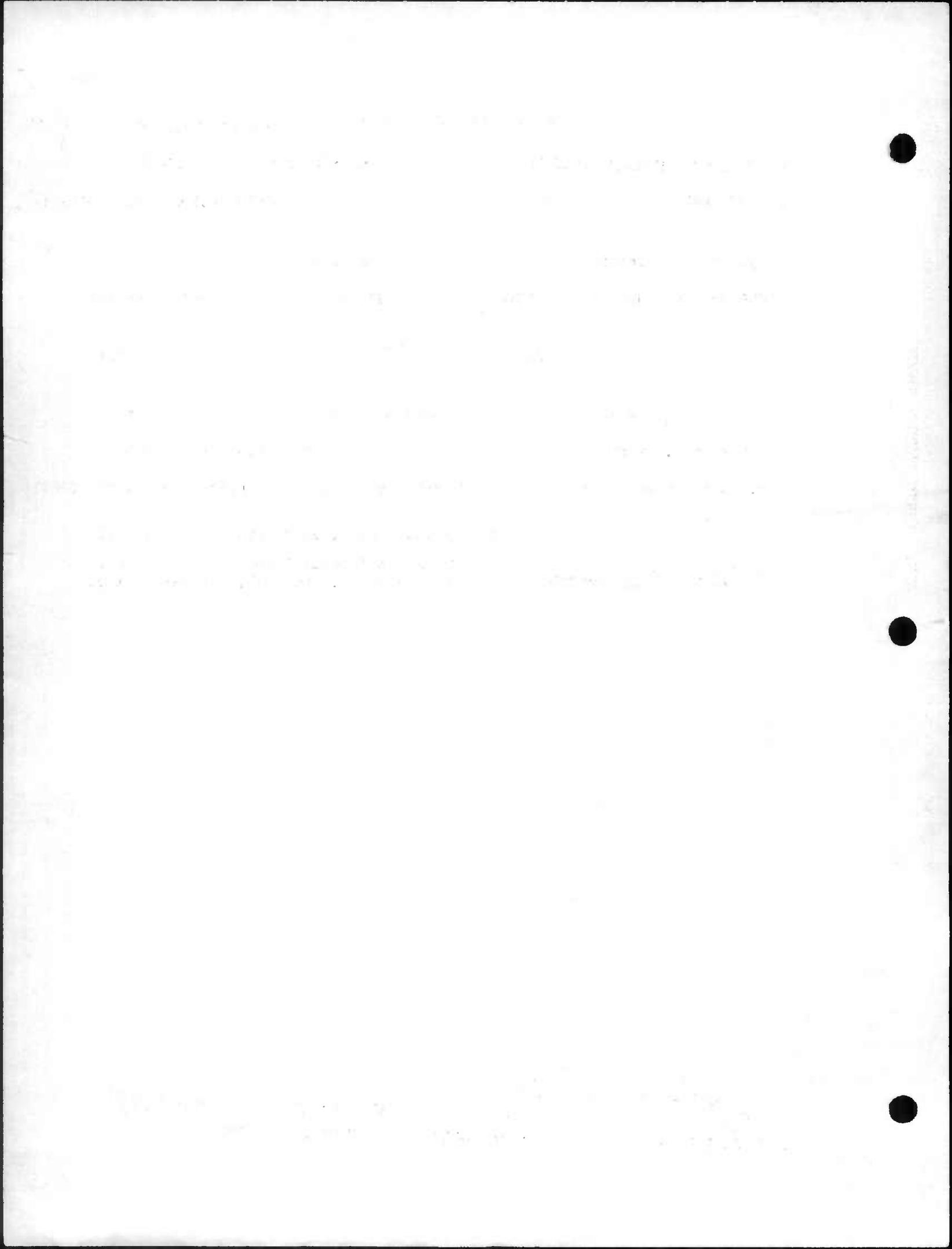
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04648

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy Tripp</b>				2. Date of Death Month Day Year <b>February 14 1999</b>		3. Time of Death <b>550AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Geriatric Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>216-05-2767</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>8-23-1918</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent				10a. State <b>MD</b>		10b. County <b>NA</b>		
To Be Completed by Funeral Director	10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>5505 Hopkins Bayview Cir.</b>		
	10f. Zip Code <b>21224</b>				10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> Collega (1-4or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DOMESTIC</b>		16b. Kind of Business/Industry <b>Homes</b>		
	17. Father's Name (First, Middle, Last) <b>Archie Falton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EVA FALTON</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Allice Bellamy guardian</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1000 Cathedral Street Baltimore MD 21217</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION</b>		20c. Location - City or Town, State <b>217/99 Lansdown MD</b>		21. Signature of Funeral Service Licensee 		
	22. Name and Address of Facility <b>Albert P. Wylie Sr PA 638 N. ELLMOR ST BALD. MD</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Cause (Final disease or condition resulting in death) a. <b>Pneumonia</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Stroke, vascular dementia, Chronic Obstructive Pulmonary Disease</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Joel C Bolen MD</b>				29c. License number <b>D53616</b>		29d. Date signed (Month, Day, Year) <b>February 14, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joel C Bolen MD 5505 Hopkins Bayview Circle, Baltimore, Maryland 21224</b>									
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>				32. Registrar's Signature <b>Bevera B. Sparks</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

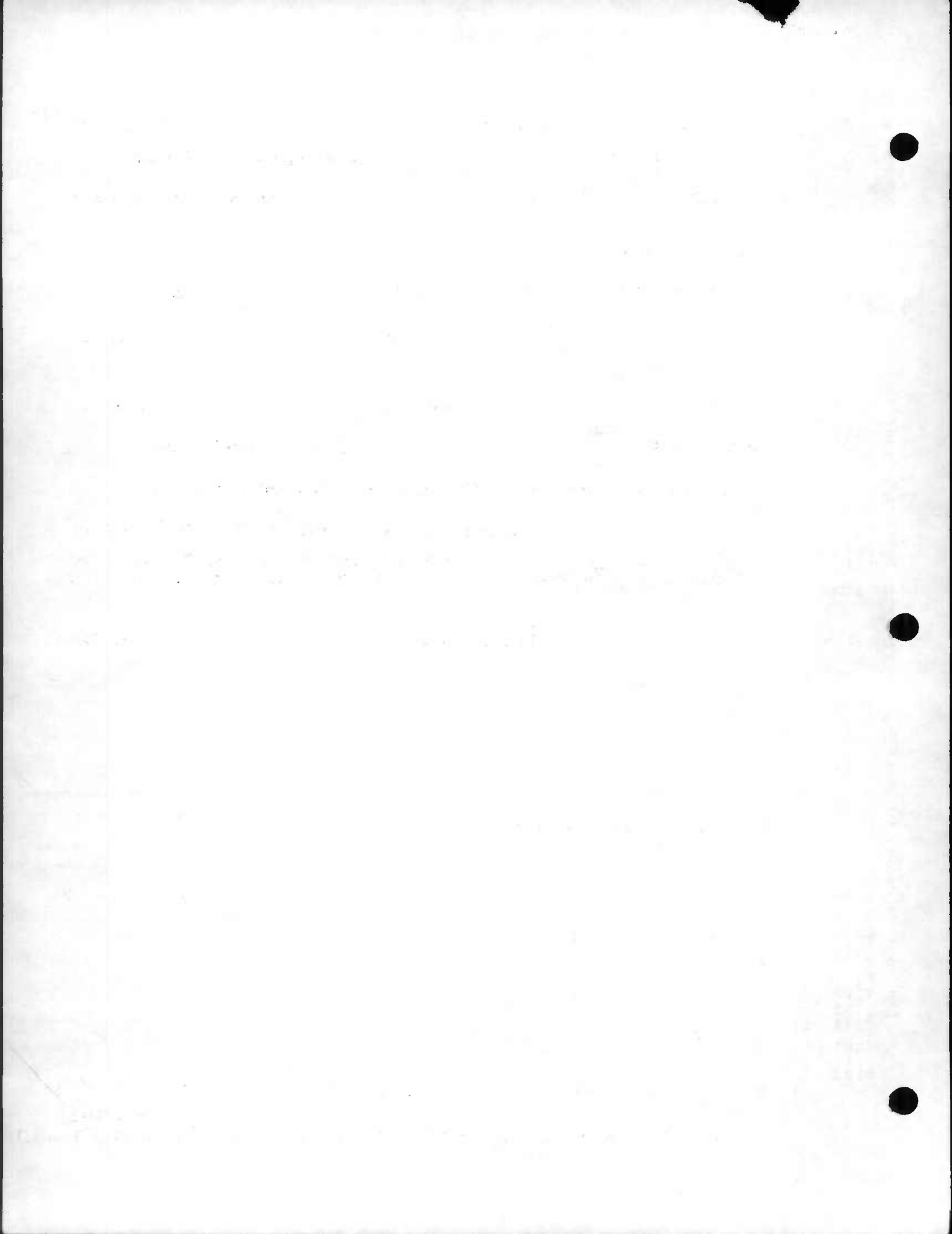
Medical Certification: To Be Completed by Physician/Medical Examiner

2 REM

State  
Registrar







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04650

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLOTTE ELIZABETH WILSON</b>				2. Date of Death Month <b>FEBRUARY</b> Day <b>16</b> Year <b>1999</b>		3. Time of Death <b>1:00am</b>	
	4a. Facility Name (If not institution, give street and number) <b>1515 BARRACK LANE (res.)</b>				4b. City, Town, or Location of Death <b>GLEN BURNIE</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>217-34-6894</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year <b>01/02/1928</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>GLEN BURNIE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1515 BARRACK LANE</b>				10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk</b> College (1-4 or 5+) <b>unk</b>				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unk</b>			16b. Kind of Business/Industry <b>unk</b>	
17. Father's Name (First, Middle, Last) <b>Hugh Hughes</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Hughes</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Charles Wilson</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1515 Barrack Lane, Glen Burnie, MD 21061</b>			
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		Date		20c. Location - City or Town, State <b>Arbutus, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Leroy O. Dyett</b>					22. Name and Address of Facility <b>LEROY O. DYETT &amp; SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD 21207</b>			
23a. Part I. Under the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic Breast Cancer</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>5 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28e. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Julie R Brahmer, MD</b>					29c. License number <b>D0051770</b>		29d. Date signed (Month, Day, Year) <b>February 18, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Julie R Brahmer, MD Johns Hopkins Hospital Baltimore MD 21287</b>								
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>			32. Registrar's Signature <b>B. Sparks</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

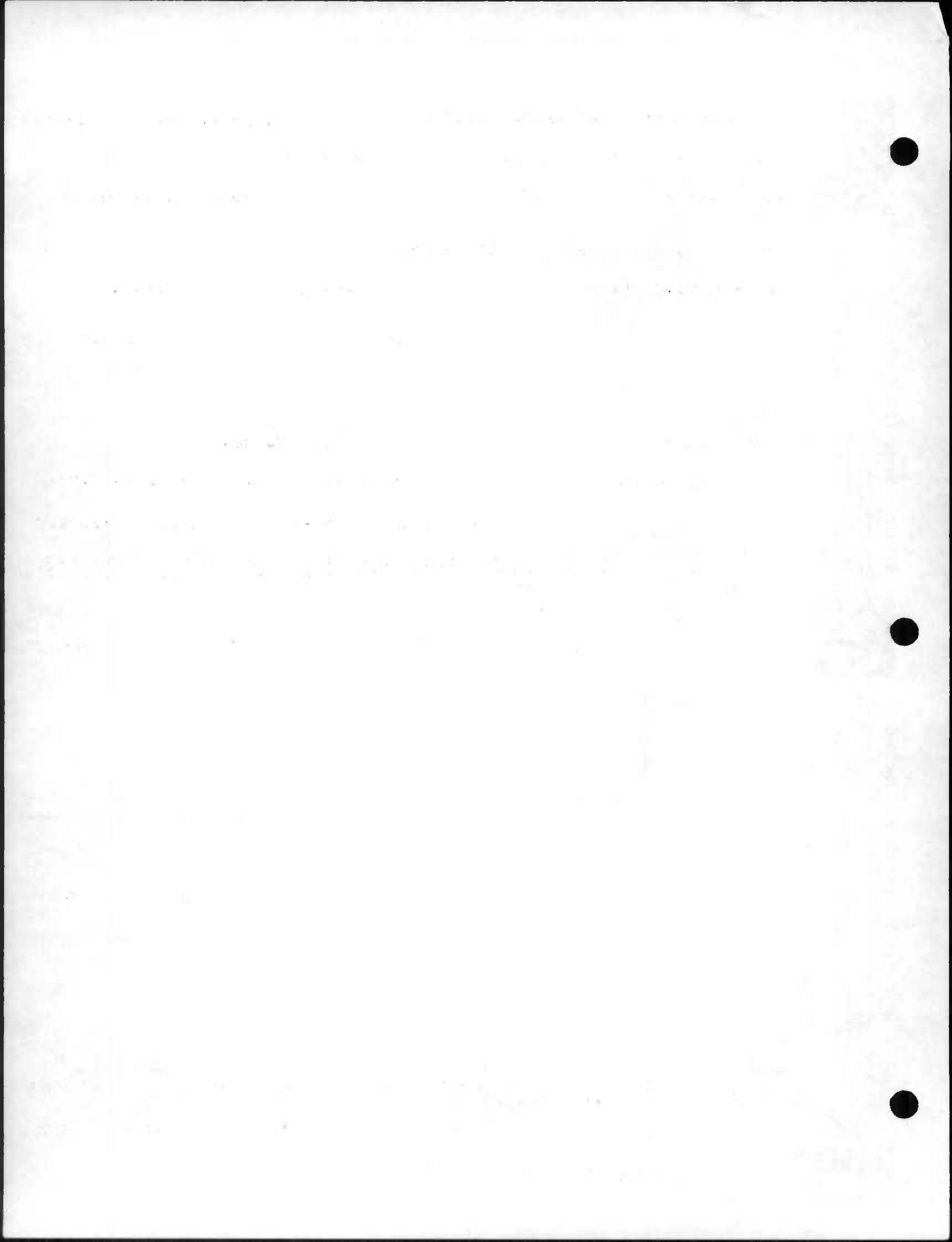
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04651

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GERTRUDE WEINSTEIN</b>				2. Date of Death Month <b>FEBRUARY</b> Day <b>10</b> Year <b>1999</b>				3. Time of Death <b>2 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>JEWISH CONVALESCENT NURSING HOME</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>215-12-0967</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>98</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>04/05/00</b>		9. Birthplace (State or Foreign Country) <b>RUSSIA</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>7920 SCOTTS LEVEL ROAD</b>				10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>CAUCASIAN</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOUSEWIFE</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>				16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>EPHRAIM</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SHAPIRO SARAH UNKNOWN</b>						
19a. Informant's Name/Relationship (Type, Print) <b>FREDERICK WEINSTEIN / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6 HARROW COURT - BALTIMORE, MD 21208</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH EL MEMORIAL PARK</b>		Date <b>2/12/99</b>		20c. Location - City or Town, State <b>RANDALLSTOWN, MD</b>		
21. Signature of Funeral Service Licensee <b>Scott M. Cutler</b>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MYOCARDIAL INFARCTION - IMMEDIATE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Dr. Sunshing MA</b>				29c. License number <b>D15140</b>		
				29d. Date signed (Month, Day, Year) <b>FEBRUARY 10, 1999</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. SUNSHING MA</b>				31. Date filed (Month, Day, Year) <b>FEB 17 1999</b>						
				32. Registrar's Signature <b>G. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04652

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Witkowski

2. Date of Death

Month  
2Day  
11Year  
99

3. Time of Death

11:23 AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-09-6871

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
2/11/17

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

804 S. MILTON AVE.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8College (1-4 or 5+)  
0

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DISABLED

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

FRANK DEMBECK

18. Mother's Name (First, Middle, Maiden Surname)

STELLA EKIELSKA

19a. Informant's Name/Relationship (Type, Print)

MR. WALTER DEMBECK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

804 S. MILTON AVE. BALTIMORE, MD. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SACRED HRT. OF MARY 2/13/99

Date

20c. Location - City or Town, State

DUNDALK, MD.

21. Signature of Funeral Service Licensee

Charles Kaczorowski

22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME P.A.

2525 FLEET STREET BALTIMORE, MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

b. Myocardial infarction

Due to (or as a consequence of):

c. Renal failure

Due to (or as a consequence of):

d. Urinary tract infection

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Fern Jeffries MD

29c. License number

D47749

29d. Date signed (Month, Day, Year)

2/11/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Fern Jeffries, MD 2435 W. Belvedere Avenue, Hutterer #2, Baltimore, MD 21215

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

Geneva A. Spade

State  
Registrar

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04653

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Samuel Salvatore Zito				2. Date of Death Month Day Year February 16, 1999		3. Time of Death 4:25 P.M.				
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death BALTIMORE				
Funeral Director	5. Social Security Number 213-20-2825		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 30, 1924				
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent		10a. State MD		10b. County Baltimore				
10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 14 East Overlea Ave. Apt. 7		10f. Zip Code 21206		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1947		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor of Maintenance		16b. Kind of Business/Industry Colleges of Loyola & Notre Dame		17. Father's Name (First, Middle, Last) Louis Zito		18. Mother's Name (First, Middle, Maiden Surname) Rose M. Barranco		19. Informant's Name/Relationship (Type, Print) Mr. John Zito/ brother			
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 K Clifford Lane Forest Hill, MD 21050		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		20c. Location - City or Town, State 02/19/99 Baltimore, Maryland		21. Signature of Funeral Service Licensee Stephen D. Coster			
22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypoxemia Aspiration Pneumonia 6 Hours Due to (or as a consequence of): b. Cerebrovascular Accident 17 DAYS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dr. Davis MD		29c. License number RD 188821			
29d. Date signed (Month, Day, Year) 2/16/99		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR GERRI DAVIS 9000 Franklin Square DR. BALTIMORE, MARYLAND 21237		31. Date filed (Month, Day, Year) FEB 18 1999		32. Registrar's Signature B. Sparks		State Registrar			

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04654

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>HAZEL MAY ALDAMA</b>		2. Date of Death Month Day Year <b>FEBRUARY 02 1999</b>		3. Time of Death <b>8:55 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>WASHINGTON ADVENTIST HOSPITAL</b>		4b. City, Town, or Location of Death <b>Albany Park</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>578-74-8710</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs/ last birthday) <b>61</b> Yrs.	8. Date of Birth Month, Day, Year <b>Jan. 02, 1938</b>		9. Birthplace (State or Foreign Country) <b>CUBA</b>
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>Prince Georges</b>	10c. City, Town or Location <b>Hyattsville</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. Street and Number <b>2403 Lewisdale Drive</b>		10f. Zip Code <b>20783</b>		10g. Citizen of What Country? <b>U.S.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Cuban</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TEACHER</b>		16b. Kind of Business/Industry <b>Education</b>	
17. Father's Name (First, Middle, Last) <b>Joseph O. Edwards</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>HAZEL M. O'CONNOR</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Kalana Jones</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2403 Lewisdale Dr, Hyattsville, MD 20783</b>			
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GATE OF HEAVEN</b>		20c. Location - City or Town, State <b>2-6-99 Silver Spring, MD</b>	
21. Signature of Funeral Service Licensee <b>Chifton Layman</b>		22. Name and Address of Facility <b>1722 N. CAPITOL ST. N.W. WASHINGTON, D.C. 20002 SAMARITAN FUNERAL HOME INC</b>			
23a. Pertinent disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) a. <b>Cardiorespiratory Arrest</b> Due to (or as a consequence of): b. <b>Ischemic Heart Disease</b> Due to (or as a consequence of): c. <b>Atherosclerosis</b> Due to (or as a consequence of): d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
<b>Severe Anemia; Acute Cerebral Infarct; Renal Failure Dialysis Dependent; Diabetes Mellitus</b>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Jose F. Bonelli MD</b>		29c. License number <b>D35055</b>		29d. Date signed (Month, Day, Year) <b>2/2/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOSE F. BONELLI, MD 8807 Colesville Rd Ste 101, Silver Spring, Md 20910</b>					
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature <b>[Signature]</b>			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04655

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Donald Lee Atwell</b>				2. Date of Death Month <b>February</b> Day <b>4</b> , Year <b>1999</b>				3. Time of Death <b>5:40 P.M.</b>					
4a. Facility Name (If not institution, give street and number) <b>Frederick Health Care Center</b>				4b. City, Town, or Location of Death <b>Frederick</b>				4c. County of Death <b>Frederick</b>					
5. Social Security Number <b>219-34-9344</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>59</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>March 15, 1939</b>		9. Birthplace (State or Foreign Country) <b>Wash. D.C.</b>	
Usual Residence of Decedent													
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Monrovia</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>12418 Fingerboard Road</b>				10f. Zip Code <b>21770</b>				10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Produce Stocker</b>				16b. Kind of Business/Industry <b>Grocery</b>					
17. Father's Name (First, Middle, Last) <b>Frederick John Atwell</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Lee</b>							
19a. Informant's Name/Relationship (Type, Print) <b>William T. Atwell / Brother</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11401 Ridge Lane, Monrovia, Md. 21770</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resthaven Crematory</b>				Date <b>Feb 5, 1999</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Ernest A. Riley, Jr.</b>				22. Name and Address of Facility <b>Leasure-Stein Funeral Home 230 Baltimore Avenue Cumberland, Md. 21502</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Squamous Cell Cancer, Head &amp; Neck</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death <b>18 months</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier <b>Don L. Miller MD</b>						29c. License number <b>D21944</b>		29d. Date signed (Month, Day, Year) <b>2/5/99</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JAMES S. GRISSON MD 300 W 9th ST. FREDERICK, MD 21701</b>													
31. Date filed (Month, Day, Year) <b>FEB 08 1999</b>		32. Registrar's Signature <b>[Signature]</b>											

State  
Registrar

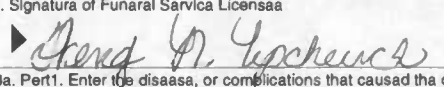
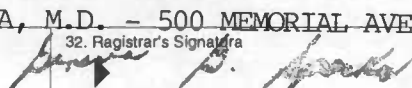


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04656

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GARY LAMAR APPEL, SR.</b>						2. Date of Death Month Day Year <b>JANUARY 31, 1999</b>		3. Time of Death <b>7:20 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>DEVLIN MANOR NURSING HOME</b>						4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>218-34-4910</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>60</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 28, 1939</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>ALLEGANY</b>		10c. City, Town or Location <b>CUMBERLAND</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>316 BEALL STREET</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b>College (1-4or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SELF-EMPLOYED</b>			16b. Kind of Business/Industry <b>HOME IMPROVEMENTS</b>			
17. Father's Name (First, Middle, Last) <b>LEO F. APPEL</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>GEORGIE L. McFARLAND</b>				
19a. Informant's Name/Relationship (Type, Print) <b>JEAN ROBERTSON APPEL / WIFE</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>316 BEALL STREET, CUMBERLAND, MD 21502</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PROSPERITY CEMETERY</b>		20c. Date <b>2/4/99</b>		20d. Location - City or Town, State <b>FLINTSTONE, MD</b>		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>BRONCHOLONGIC CARCINOMA</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>2 YRS.</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 						29c. License number <b>D14865</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 2, 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ROBERTIANO BARRERA, M.D. - 500 MEMORIAL AVENUE, CUMBERLAND, MD 21502</b>										
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>				32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04657

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY MARGARET ALLNUTT

2. Date of Death  
Month Day Year  
Feb 1 19993. Time of Death  
9 am

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville MD

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-03-7955

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Apr 10 1919

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10e. State

MD

10b. County

Montgomery

10c. City, Town or Location

Boys

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17101 W. Old Baltimore Road

10f. Zip Code

20838

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

secretary

16b. Kind of Business/Industry

secretarial

17. Father's Name (First, Middle, Last)

Francis Leo Smith

18. Mother's Name (First, Middle, Maiden Surname)

Emma Carr

19a. Informant's Name/Relationship (Type, Print)

R. Cromwell Allnutt/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 413 Barnesville, MD 20838

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet

Date

3/5

20c. Location - City or Town, State

Frederick, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Hilton Funeral Home

Barnesville, MD 20838

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

b. BRONCHIECTASIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

4 DAYS

10 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 26540

29d. Date signed (Month, Day, Year)

FEB 1 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carl L. Schoenberger 16220 Frederick Rd. Gaithersburg

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: #5 PER F H G769 3-2-99 WR  
Amend. 20a 2/3/99 SM AACO Health

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04658

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Ronald Adkins</b>				2. Date of Death Month <b>February</b> Day <b>1</b> Year <b>1999</b>		3. Time of Death <b>6:40 am</b>	
4a. Facility Name (If not institution, give street and number) <b>412 Ridgeview Court</b>				4b. City, Town, or Location of Death <b>Arnold</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>577-48-2406</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>64</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 3, 1934</b>	
9. Birthplace (State or Foreign Country) <b>Kentucky</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Arnold</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>412 Ridgeview Court</b>		10f. Zip Code <b>21012</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>		16b. Kind of Business/Industry <b>NASA</b>		17. Father's Name (First, Middle, Last) <b>Carl Whitacker</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Klaire Adkins</b>		19a. Informant's Name/Relationship (Type, Print) <b>Mary Adkins / wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>412 Ridgeview Court, Arnold, MD 21102</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>entombment</b>	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakemont Mem. Gardens</b>		20c. Location - City or Town, State <b>Davidsonville, MD</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Ruptured Abdominal Aortic Aneurysm</b> Due to (or as a consequence of): <b>Hypertension</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier <b>Thomas M. Walsh M.D.</b>		29c. License number <b>D23867</b>		29d. Date signed (Month, Day, Year) <b>February 2, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Thomas Walsh, M.D., 277 Peninsula Farm Road, Arnold, MD 21012</b>	
31. Date filed (Month, Day, Year) <b>FEB 03 1999</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04659

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harriet McKenney Brown</b>				2. Date of Death Month Day Year <b>FEBRUARY 3, 1999</b>		3. Time of Death <b>1638 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>RT. 40&amp; WELLS CAMP RD.</b>				4b. City, Town, or Location of Death <b>NORTHEAST</b>		4c. County of Death <b>CECIL</b>		
Funeral Director	5. Social Security Number <b>212-28-4637</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 9, 1913</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Perryville</b>		
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>103 Woodall Road</b>		10f. Zip Code <b>21903</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) <b>Three Years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registered Nurse</b>		16b. Kind of Business/Industry <b>V.A. Medical Center Perry Point, Maryland</b>					
17. Father's Name (First, Middle, Last) <b>Joseph H. McKenney</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Mary Dean</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Joanne C. Brown (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>113 Woodall Road, Perryville, Maryland 21903</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Mark's Cemetery</b>		20c. Date <b>2/6/99</b>		20d. Location - City or Town, State <b>Perryville, Maryland</b>			
21. Signature of Funeral Service Licensee <i>Thomas M. Patterson, Sr.</i>				22. Name and Address of Facility <b>Lee A. Patterson &amp; Son Funeral Home Perryville, Maryland 21903-0188</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Multiple injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>2-3-99</b>		28b. Time of Injury <b>1631</b> M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred <b>Motor vehicle accident</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>RT 40/Wells Camp Rd Cecil County, Maryland</b>							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Stephen S. Radentz</i>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 4, 1999</b>			
30. Name and address of person who completed cause of death (Item 25a) (Type, Print) <b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date of Death (Month, Day, Year) <b>FEB 08 1999</b>		32. Registrar's Signature <i>P. Sparks</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04660

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SANDRA DULA BROWN</b>				2. Date of Death Month Day Year <b>February 3, 1999</b>		3. Time of Death <b>14:00</b>	
	4a. Facility Name (If not institution, give street and number) <b>3148 Turkey Point Road</b>				4b. City, Town, or Location of Death <b>North East</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>216-48-0745</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>49</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>February 21, 1949</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>North East</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3148 Turkey Point Road</b>				10f. Zip Code <b>21901</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Shipping &amp; Receiving Manager</b>			16b. Kind of Business/Industry <b>Steel slitting company</b>	
17. Father's Name (First, Middle, Last) <b>Odell Dula</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margie Myers</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Belinda Sheets / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13 Kitty Lane, Newark, DE 19713</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>North East Methodist Cem.</b>		20c. Location - City or Town, State <b>Feb. 6 1999 North East, Maryland</b>		
21. Signature of Funeral Service Licensee				22. Name and Address of Facility <b>Crouch Funeral Home 127 South Main Street, North East, MD 21901</b>				
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. widely metastatic lung cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number <b>D45755</b>				
29b. Signature and title of certifier				29d. Date signed (Month, Day, Year) <b>02/04/1999</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>John R. Mulvey, M.D. 111 W. High Street, Suite 214, Elkton, MD 21921</b>								
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>				32. Registrar's Signature <b>[Signature]</b>				

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

The first part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

The second part of the document is a series of paragraphs of text, written in a cursive script. The text is somewhat faded and difficult to read, but it appears to be a narrative or a report. The paragraphs are separated by small gaps, and the text is written in a consistent style throughout.

The third part of the document is a list of names and dates, similar to the first part. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into columns, with names in the first column and dates in the second column.

The fourth part of the document is a series of paragraphs of text, written in a cursive script. The text is somewhat faded and difficult to read, but it appears to be a narrative or a report. The paragraphs are separated by small gaps, and the text is written in a consistent style throughout.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04661

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jack Lynn Bonsall</b>					2. Date of Death Month Day Year <b>February 5, 1999</b>		3. Time of Death <b>8:35 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>8808 Dement Court</b>					4b. City, Town, or Location of Death <b>Waldorf</b>		4c. County of Death <b>Charles</b>			
Funeral Director	5. Social Security Number <b>185-18-6413</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 18, 1920</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>Pennsylvania Clearfield</b>		10b. County <b>Grampian</b>		10c. City, Town or Location				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>P. O. Box 199</b>				10f. Zip Code <b>16838</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mail Carrier</b>			16b. Kind of Business/Industry <b>Postal Service</b>				
	17. Father's Name (First, Middle, Last) <b>James Ivan Bonsall</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Violet Seger</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Helen L. Bonsall - wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. Box 199, Grampian, PA 16838</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Friends Cemetery</b>		Date <b>2-10-99</b>		20c. Location - City or Town, State <b>Grampian, PA</b>				
	21. Signature of Funeral Service Licensee <b>Mark G. Brohawn M00053</b>					22. Name and Address of Facility <b>Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARDIAC FAILURE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>										Approximate Interval Between Onset and Death <b>Yrs</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>(Son)</b>						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Dr. Krishan Mathur</b>		29c. License number <b>028352</b>		29d. Date signed (Month, Day, Year) <b>2/5/99</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Krishan Mathur, 3500 Old Washington Road, #102, Waldorf, MD 20602</b>											
State Registrar	31. Date filed (Month, Day, Year) <b>FEB 09 1999</b>					32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04662

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walton H. Burroughs Sr.				2. Date of Death Month Day Year February 5, 1999		3. Time of Death 4:45AM		
	4a. Facility Name (If not institution, give street and number) 14411 South Springfield Road				4b. City, Town, or Location of Death Brandywine		4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 579-18-7168		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 23, 1914	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Brandywine		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 14411 South Springfield Road				10f. Zip Code 20613		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Driver		16b. Kind of Business/Industry Board of Education		
	17. Father's Name (First, Middle, Last) Robert D. Burroughs				18. Mother's Name (First, Middle, Maiden Surname) Cora Johnson				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Priscilla Burroughs- Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14411 South Springfield Road Brandywine, Maryland 20613				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Union Bethel A.M.E. Cem.		Date Feb. 9, 1999		20c. Location - City or Town, State Brandywine, Maryland		
	21. Signature of Funeral Service Licensee <i>Lloyd M. Gatz</i>				22. Name and Address of Facility Adams Funeral Home Aquasco, Maryland 20608				
	23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Probable Progressive Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of MI 1978 with Coronary Artery Disease						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Sheldene, MD</i>		29c. License number D38698		29d. Date signed (Month, Day, Year) 2/8/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. C. OH, MD, 11340 Pembroke Square Waldorf Maryland 20603									
31. Date filed (Month, Day, Year) FEB 08 1999		32. Registrar's Signature <i>Barbara B. Sparks</i>							



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04663

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evelyn Myrtle Burgess				2. Date of Death Month Day Year 2 3 99				3. Time of Death 3:15 PM		
	4a. Facility Name (If not institution, give street and number) Rainbow Hall Baptist Home				4b. City, Town, or Location of Death Owings Mills				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 577-38-0014		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) August 5, 1905		9. Birthplace (State or Foreign Country) Washington, DC		
	Usual Residence of Decedent				10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Owings Mills		
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 10729 Park Heights Avenue				10f. Zip Code 21117		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry United States State Department			
17. Father's Name (First, Middle, Last) Ewell France						18. Mother's Name (First, Middle, Maiden Summa) Maude Hutchinson					
19a. Informant's Name/Relationship (Type, Print) Kent R. Burgess - Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3906 West Shore Drive, Edgewater, MD 21037					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery				20c. Date 02/05/99		20d. Location - City or Town, State Brentwood, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <u>hypertension</u> Due to (or as a consequence of):											~10 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):											
c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>advanced dementia</u>											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) NA		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number D41104		29d. Date signed (Month, Day, Year) 2 3 99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ted Hale MD 7825 York Rd Towson MD 21204											
31. Date filed (Month, Day, Year) FEB 05 1999				32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

020 20 034

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04664

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marcia Puahana Baldwin

2. Date of Death

February 3, 1999

3. Time of Death

3:55AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

579-52-7385

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 18, 1939

9. Birthplace (State or Foreign Country)

Hawaii

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Riverdale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5305 Riverdale Road #25

10f. Zip Code

20737

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Polynesian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Health Clinic

17. Father's Name (First, Middle, Last)

(Unavailable)

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Thexeria

19a. Informant's Name/Relationship (Type, Print) (Daughter)

Travis Renee Baldwin-Chrisinger

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5305 Riverdale Road #13, Riverdale, MD 20737

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

02/04/99

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Henry S. Furl

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CEREBROVASCULAR ACCIDENT

Approximate Interval Between Onset and Death

2 DAYS

Due to (or as a consequence of):

INTRA CEREBRAL HEMORRHAGE

2 DAYS

Due to (or as a consequence of):

HYPERTENSION

MANY YEARS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

VP S. Furl Attest: Dr. Puahana Baldwin

29c. License number

019897

29d. Date signed (Month, Day, Year)

2.3.99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

V. SINICH 7209A HANOVER PARKWAY GREENBELT MD 20770

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

A. Furl

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3





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State of Maryland / Department of Health and Mental Hygiene

99 04665

Amend Item #19. Per FH PGC 2-10-99 cr

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RICHARD L. BROWN</b>				2. Date of Death Month Day Year <b>January 30, 1999</b>		3. Time of Death <b>2:25 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Maryland Mariner Health Care Center of Southern</b>				4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>		
Funeral Director	5. Social Security Number <b>577-40-4207</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 21, 1931</b>		
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Capitol Heights</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>909 Flores St.</b>		10f. Zip Code <b>20743</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Tractor Tractor Driver</b>		16b. Kind of Business/Industry <b>Private</b>			
17. Father's Name (First, Middle, Last) <b>Richard L. Brown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Nelson</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Sylvia Brown - Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>909 Flores St., Capitol Heights, MD 20743</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cem.</b>		Date <b>2/8/99</b>		20c. Location - City or Town, State <b>Cheltenham, MD</b>			
21. Signature of Funeral Service Licensee <i>John T. Stewart III</i>		22. Name and Address of Facility <b>Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e. <b>multiple decubitus ulcer with sepsis</b> Due to (or as a consequence of): b. <b>cerebrovascular Accident</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>EDD</b> <b>Dementia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D46478</b>		29d. Date signed (Month, Day, Year) <b>2-2-99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Suresh A. Patchamp 7501 Surattas Rd 307. Clinton. MD 20735</b>									
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature <i>[Signature]</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

2924 J. Neurosci., July 26, 2006 • 26(30):2919–2925

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04666

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES THOMAS BOOTH

2. Date of Death  
Month Day Year  
January 29, 19993. Time of Death  
2:45 P.M.

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-16-8369

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

1/21/19

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9949 Parks Street

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
9th

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Auto Inspector

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Daniel Booth

18. Mother's Name (First, Middle, Maiden Surname)

Elenora Brown

19a. Informant's Name/Relationship (Type, Print)

Ireatha A. Jolivet/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7610 Locris Dr., Upper Marlboro, Md. 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cem.

Date

2/4/99

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

Amy W. Pratt

22. Name and Address of Facility

H.S. Washington & Sons Co., Inc.  
4925 Burroughs Ave., N.E., Wash., D.C. 20019

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 DAY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DECUBITUS ULCERS

Due to (or as a consequence of):

2 MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MALNUTRITION

ASPIRATION PNEUMONIA.

DEMENTIA, MULTI-INFARCT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

HAMMETT MD

29c. License number

D39966

29d. Date signed (Month, Day, Year)

01/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

344 UNIVERSITY BLVD W SUITE 326 SILVER SPRING, MD

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

A. Adams

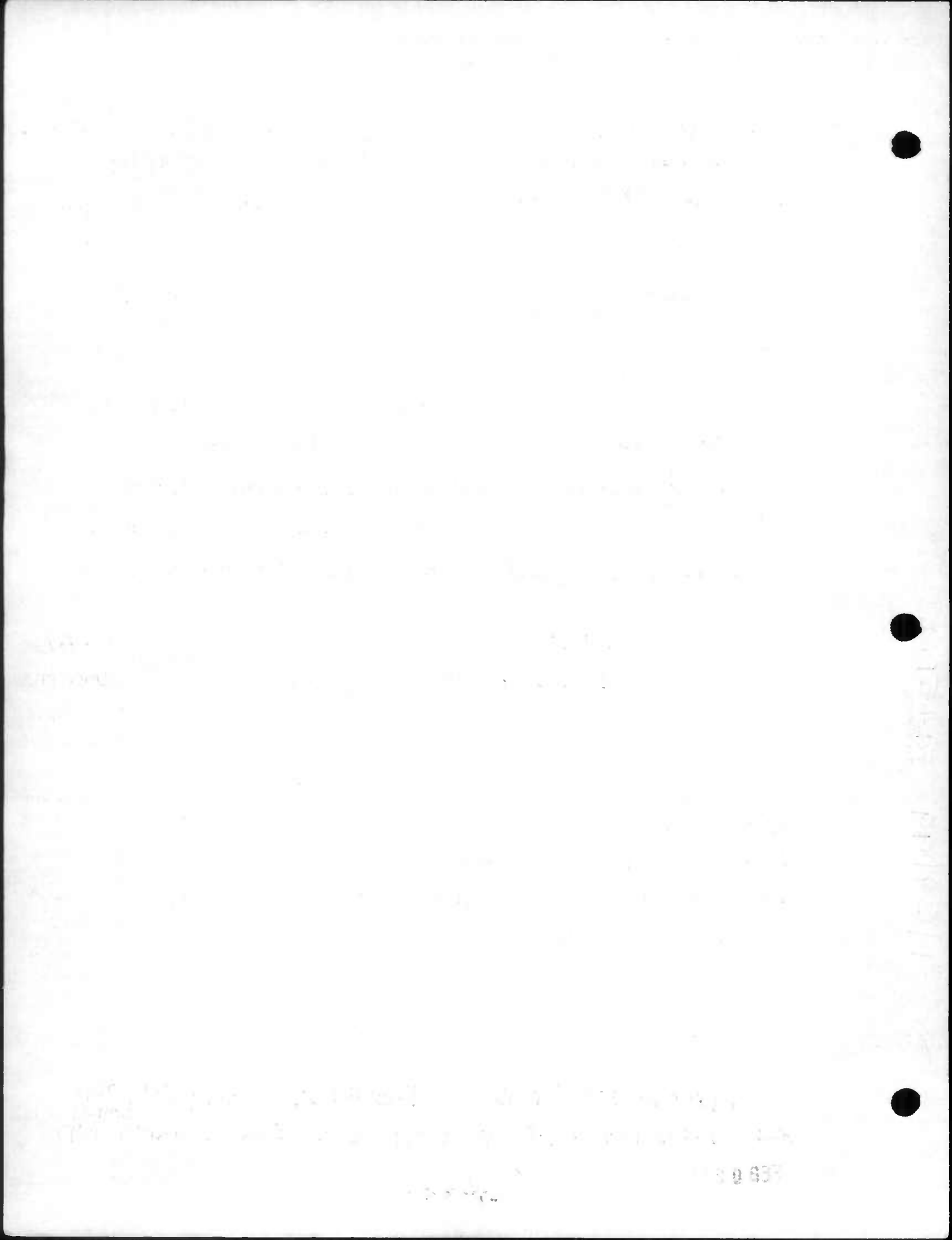
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04667

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JEANICE BAILEY</b>		2. Date of Death Month <b>JAN</b> Day <b>30</b> Year <b>1999</b>		3. Time of Death <b>12:20 pm</b>
	4a. Facility Name (If not institution, give street and number) <b>Woodside Nursing Center 9101 Second Ave.</b>		4b. City, Town, or Location of Death <b>Silver Spring MD</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>141-01-1412</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>9/9/17</b>	9. Birthplace (State or Foreign Country) <b>USA</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>MONTGOMERY</b>	10c. City, Town or Location <b>SILVERSPRING</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>9101 2ND AVENUE</b>		10f. Zip Code <b>20910</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/> <b>COLLEGE + MASTERS EDUCATION ADMINISTRATOR</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>Education</b>		
	17. Father's Name (First, Middle, Last) <b>Henry Turner</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mattie (Unknown)</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Vernon Bailey - Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4411 13th Place NE Washington, DC 20018</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington Crematory</b>		20c. Location - City or Town, State <b>1/31/99 Arlington, VA</b>
	21. Signature of Funeral Service Licensee <b>Reginald E. Collier</b>		22. Name and Address of Facility <b>Wm. F. Magruder Funeral Home 2311 MLK Jr. Ave. SE Washington, DC 20020</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Cerebrovascular Disease</b> Due to (or as a consequence of): b. <b>Diabetes</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>28d. Describe how injury occurred</b> <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Gail Povar MD</b>					
29c. License number <b>D 46101 Maryland</b>					
29d. Date signed (Month, Day, Year) <b>1/31/99</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GAIL POVAR MD 8700 Georgia Ave. Suite 400 Silver Spring Md. 20910</b>					
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>					
32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar





State of Maryland / Department of Health and Mental Hygiene

## Reg. No.

99 04668

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than "natural", or Items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

ORIGINAL



Handwritten signature or mark.

000 2 0 637

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04669

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH ELIZABETH BULGER

2. Date of Death

Month Day Year  
Feb. 1, 1999

3. Time of Death

1:30 p.m.

4a. Facility Name (If not institution, give street and number)

220 SOMERVILLE AVENUE APT 302

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

214-80-4243

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Jul 11, 1917

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

220 Somerville Avenue

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank Kelley

18. Mother's Name (First, Middle, Maiden Surname)

Martha (Brinkerhoff)

19a. Informant's Name/Relationship (Type, Print)

Donald Bulger--son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

320 Race Street; Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Columbiana County Cem

Date

02/05

20c. Location - City or Town, State

East Liverpool, OH

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.  
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sudden cardiac death

Due to (or as a consequence of):

CAD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sudden

Feb. 1993

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Macular degeneration  
Depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H.C. Merrick

29c. License number

D28910

29d. Date signed (Month, Day, Year)

Feb. 1, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

H.C. Merrick, M.D.; 500 Memorial Avenue; Cumberland, MD 21502

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

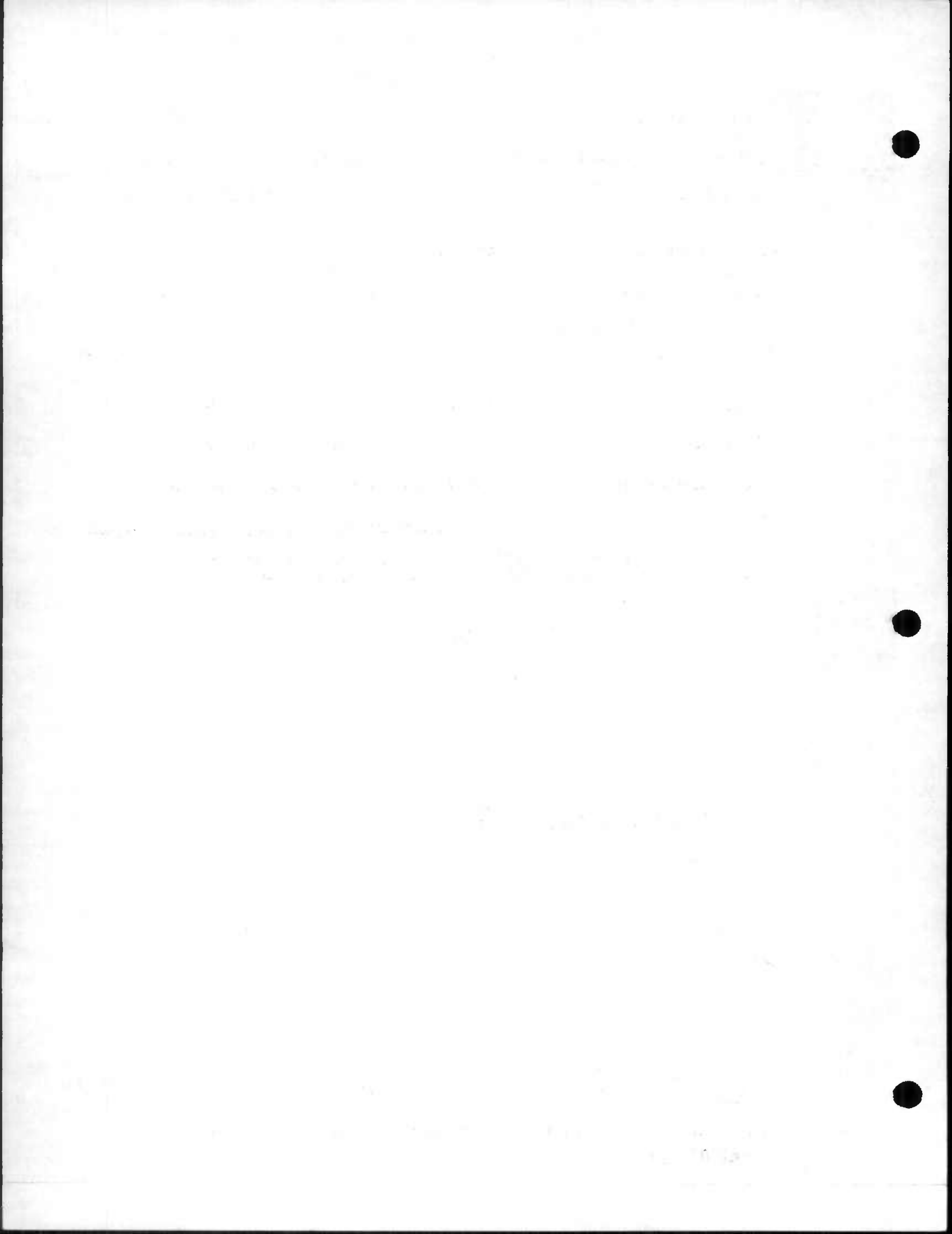
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04670

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Boyd T. Bohrer</b>						2. Date of Death Month Day Year <b>February 4, 1999</b>		3. Time of Death <b>18:30</b>		
	4a. Facility Name (If not institution, give street and number) <b>Allegany County Nursing Home</b>						4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>		
Funeral Director	5. Social Security Number <b>219-03-9276</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b>		8. Date of Birth (Month, Day, Year) <b>Mar. 18, 1906</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>1 Baltimore Street</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance man</b>			16b. Kind of Business/Industry <b>School system</b>				
17. Father's Name (First, Middle, Last) <b>Howard W. Bohrer</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Daisy M. (Miller)</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Erma B. Bechtol</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 Arlene Trail, Fairfield, PA 17302</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pleasant Grove Cemetery</b>			20c. Date <b>2/7/99</b>		20d. Location - City or Town, State <b>Cumberland, MD</b>			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Kight Funeral Home</b> <b>309-311 Decatur St., Cumberland, MD 21502</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARCINOMA OF THE PROSTATE WITH BONE METASTASIS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>										Approximate Interval Between Onset and Death <b>10 years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 						29c. License number <b>D-14865</b>		29d. Date signed (Month, Day, Year) <b>FEB. 5, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBUSTIANO J. BARRERA, M.D., MEMORIAL MEDICAL BLDG. STE. 201 CUMBERLAND MD 21502</b>											
31. Date filed (Month, Day, Year) <b>FEB 08 1999</b>			32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

BOYD BOHRER 219-03-9276 Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Physician /Medical Examiner

State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 01671

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Robert William Broadwater</b>				2. Date of Death Month Day Year <b>FEBRUARY 04, 1999</b>		3. Time of Death <b>18:05P</b>	
4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
5. Social Security Number <b>215-16-4573</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 12, 1923</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Grantsville</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>159 Ravine Street</b>		10f. Zip Code <b>21536</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Carpentry</b>			
17. Father's Name (First, Middle, Last) <b>Hayward Broadwater</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillie Guinn</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Robert G. Klotz/nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 274, Grantsville, MD 21536</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Grantsville Cem.</b>		Date <b>Feb. 7, 1999</b>		20c. Location - City or Town, State <b>Grantsville, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Newman Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 21536</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial Infarction</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Hypertension</b> Due to (or as a consequence of):  <b>c. Atherosclerosis</b> Due to (or as a consequence of):  <b>d. Diabetes Mellitus</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>3 months</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC RENAL DISEASE</b> <b>INTRAVENTRICULAR BLOOD CLOT</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>031875</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 9, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Robert Welik M.D. 902 Seton Drive Cumberland, MD 21502</b>							
31. Date filed (Month, Day, Year) <b>FEB 09 1999</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

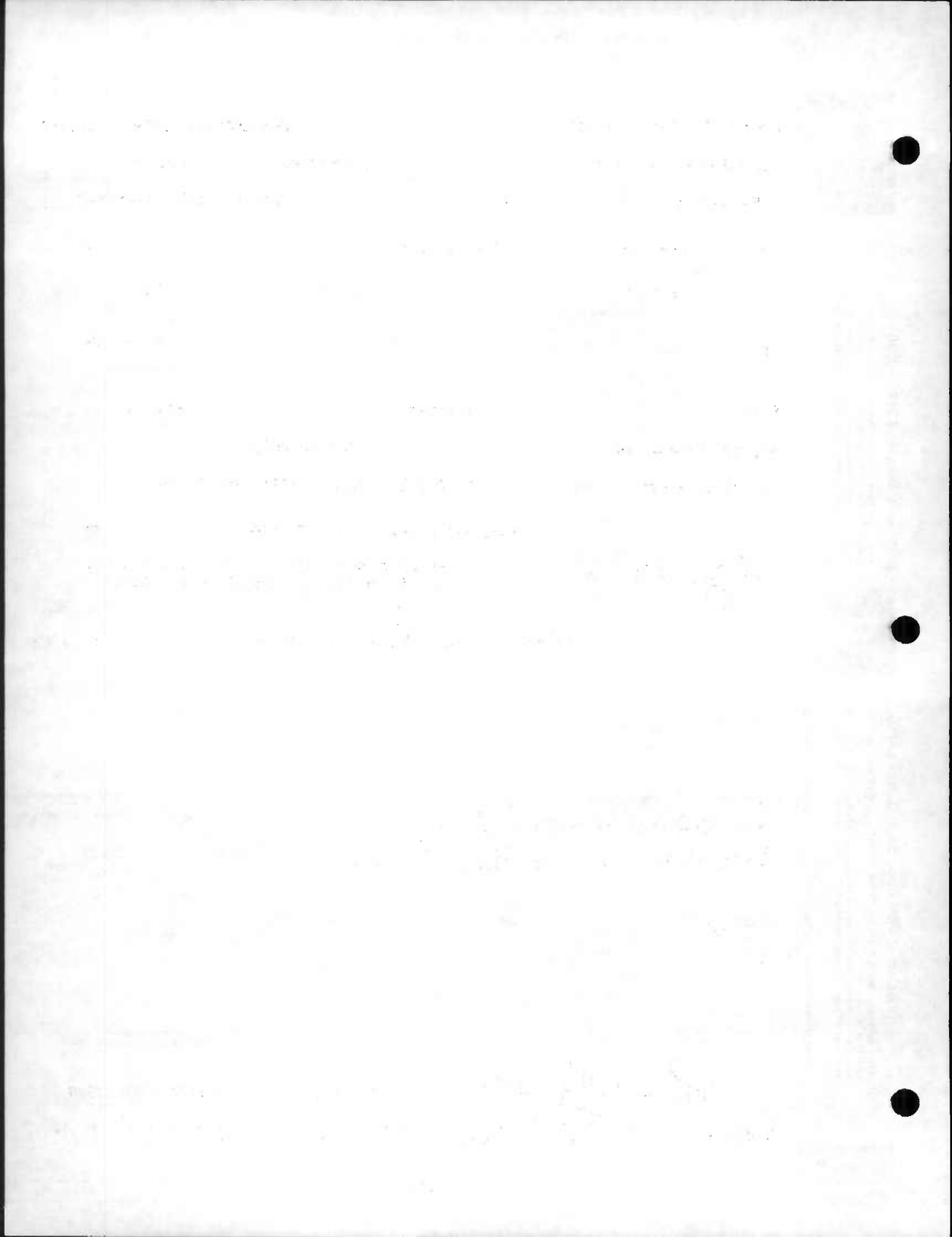
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04672

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>JOSEPH EARL BOARMAN, SR.</b>						2. Date of Death Month Day Year <b>FEBRUARY 04, 1999</b>		3. Time of Death <b>1940</b>		
4a. Facility Name (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL CENTER</b>						4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGES</b>		
5. Social Security Number <b>213 38 2483</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>60</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 31, 1938</b>		9. Birthplace (State or Foreign Country) <b>Wash., D.C.</b>		
Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Chesapeake Beach</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3620 27th Street</b>				10f. Zip Code <b>20732</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>sheet metal work foreman</b>			16b. Kind of Business/Industry <b>construction</b>			
17. Father's Name (First, Middle, Last) <b>George Thomas Boarman</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Edith Agnes Williams</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Shirley A. Boarman / wife</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as # 10 above</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery</b>		Date <b>2-8-99</b>		20c. Location - City or Town, State <b>Clinton, MD</b>		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Rausch Funeral Home, P.A., Owings, MD 20736</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>AND b. CARDIAC ARRHYTHMIA (WPW SYNDROME)</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and Title of certifier  DME						29c. License number <b>D 33954</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 05, 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>										
31. Date filed (Month, Day Year) <b>FEB 10 1999</b>				32. Registrar's Signature 						

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04673

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY BARTON

2. Date of Death

Month Day Year  
FEBRUARY 5, 1999

3. Time of Death

2:00 PM

4a. Facility Name (If not institution, give street and number)

Doctors Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

223 24 4205

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 18, 1923

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5504 Edgewood Place

10f. Zip Code

20748

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)  
College

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Daycare

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Carl Good

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Lee Breedon

19a. Informant's Name/Relationship (Type, Print)

James Beall (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10900 Brookes Reserve Road, Upper Marlboro, MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Feb 12, 1999  
Arlington National Cemetery

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pleural Effusion

Approximate Interval Between Onset and Death

2 wks.

Due to (or as a consequence of):

Hypoxia

12-24 hrs

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD Attending

29c. License number

042580

29d. Date signed (Month, Day, Year)

2-5-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PS AULIA MD 5632 Annapolis Rd #13 BLADENSBURG MD 20710.

31. Date filed (Month, Day, Year)

FEB 09 1999

32. Registrar's Signature

[Signature]

State  
Registrar

BARTON, MARY  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 04674

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KURT JOSEF BOEHM</b>				2. Date of Death Month <b>February</b> Day <b>2</b> Year <b>1999</b>		3. Time of Death <b>4:30 p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>309 Violet Court</b>				4b. City, Town, or Location of Death <b>Mount Airy</b>		4c. County of Death <b>Carroll County</b>	
Funeral Director	5. Social Security Number <b>220-76-0888</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 17, 1940</b>	
	9. Birthplace (State or Foreign Country) <b>Germany</b>		10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Mount Airy</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>309 Violet Ct.</b>		10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>		16b. Kind of Business/Industry <b>Electric</b>				
17. Father's Name (First, Middle, Last) <b>Josef Boehm</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Holaschke</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Flora R. Boehm / wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>309 Violet Ct. / Mount Airy, MD 21771</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hagerstown Crematory</b>		20c. Date <b>2-5-99</b>		20c. Location - City or Town, State <b>Hagerstown, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stauffer Funeral Home</b> <b>8 E. Ridgeville Blvd. / Mount Airy, MD 21771</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Probable arteriosclerotic cardiovascular disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ETHANOL ABUSE</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>026499</b>		29d. Date signed (Month, Day, Year) <b>2-3-99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ronald E. Miller / 4 Cullwell dr. / Mt. Airy, Maryland 21771</b>								
31. Date filed (Month, Day, Year) <b>FEB 08 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the transparency and accountability of the organization. This section also outlines the various methods used to collect and analyze data, ensuring that the information is reliable and up-to-date.

2. The second part of the document focuses on the implementation of these practices. It details the steps involved in setting up a robust system for data collection and analysis. This includes identifying the key areas of focus, selecting appropriate tools and technologies, and training staff to ensure they are equipped to handle the data effectively.

3. The third part of the document addresses the challenges that may arise during the implementation process. It provides strategies for overcoming common obstacles, such as resistance to change or limited resources. By anticipating these challenges, the organization can better prepare itself to navigate any difficulties that may arise.

4. The final part of the document concludes with a summary of the key findings and recommendations. It reiterates the importance of maintaining accurate records and provides a clear path forward for the organization. The document also includes a list of references and a glossary of terms to ensure that all readers have a clear understanding of the content.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04675

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wayne Tannehill Brooks

2. Date of Death

Month

Day

Year

02

03

99

3. Time of Death

12<sup>15</sup> AM

4a. Facility Name (If not institution, give street and number)

Mallard Bay Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

233-48-0675

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct. 16, 1913

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11 Hatsawap Rd.

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steel Industry Executive

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Dr. Omer V. Brooks

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Tannehill

19a. Informant's Name/Relationship (Type, Print)

Frances G. Brooks/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 Hatsawap Rd., Cambridge, MD 21613

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cambridge Crematory 2-4-99

Date

20c. Location - City or Town, State

Cambridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.

308 High St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of Lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Franken MD 302 Collins Hurlock md 21643

31. Date filed (Month, Day, Year)

FEB 5 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04676

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BERTHA BAREUTHER</b>				2. Date of Death Month <b>February</b> Day <b>06</b> Year <b>1999</b>		3. Time of Death <b>0620</b>		
	4a. Facility Name (If not institution, give street and number) <b>Mallard Bay Center</b>				4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>		
Funeral Director	5. Social Security Number <b>146-30-2431</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 27 1904</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>5812 Indian Quarter Rd.</b>				10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>			16b. Kind of Business/Industry <b>own home</b>		
17. Father's Name (First, Middle, Last) <b>James John Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rosina Coleman</b>					
19a. Informant's Name/Relationship (Type, Print) <b>June B. Graf - daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5812 Indian Quarter Rd., Cambridge MD 21613</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakeview Memorial Park 2-9-1999</b>			20c. Location - City or Town, State <b>Cinnaminson N.J.</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Thomas Funeral Home PA 700 Locust St. Cambridge, MD 21613</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Coronary heart disease</b> years. Due to (or as a consequence of): b. <b>Abdominal Aortic Aneurysm.</b> years. Due to (or as a consequence of): c. <b>Hypertension</b> years. Due to (or as a consequence of): d. <b>Hypertensive Cardiovascular disease</b> years.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cholelithiasis</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number <b>D50987</b>		29d. Date signed (Month, Day, Year) <b>2/8/99</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Ahmed Nawaz 105 Aurora Sweet Cambridge MD</b>									
31. Date filed (Month, Day, Year) <b>FEB 8 1999</b>				32. Registrar's Signature  <b>21613</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

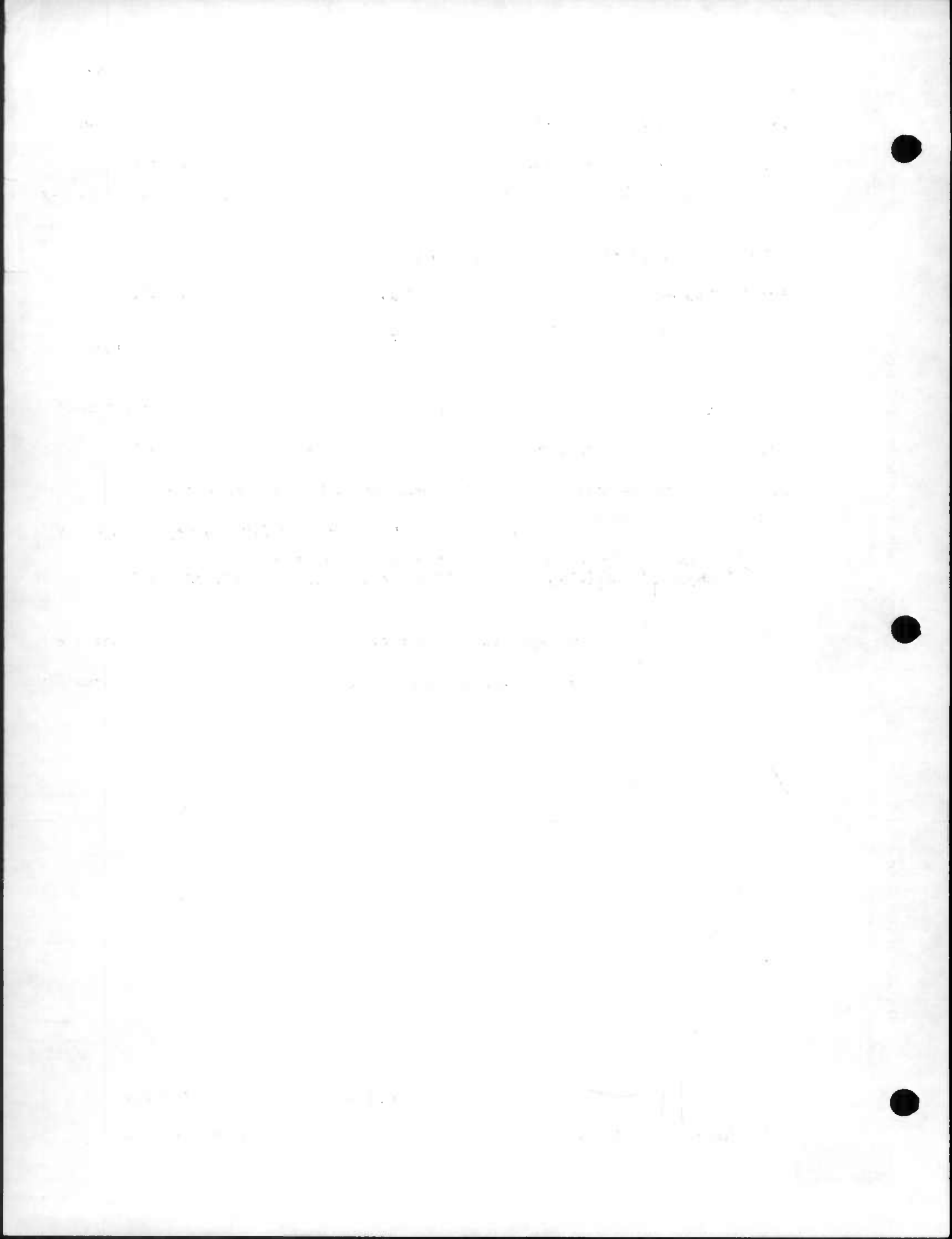
Reg. No.

99-04677

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Freda Garnnett BROWN</b>				2. Date of Death Month Day Year <b>January 13, 1999</b>				3. Time of Death <b>10:15 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Garrett County Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Oakland</b>				4c. County of Death <b>Garrett</b>		
Funeral Director	5. Social Security Number <b>277-22-0172</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 4, 1918</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Oakland</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>803 E. Chestnut St.</b>				10f. Zip Code <b>21550</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cook</b>				16b. Kind of Business/Industry <b>High School</b>				
	17. Father's Name (First, Middle, Last) <b>Howard ----- Henline</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Essie ----- Hebb</b>						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Alice L. Wilt/ Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>218 Smouse Road, Oakland, MD 21550</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Stemple Ridge Cemetery</b>		Date <b>1/16/99</b>		20c. Location - City or Town, State <b>Stemple Ridge, WV</b>				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stewart Funeral Home</b> <b>32 S. Second St., Oakland, MD 21550</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of): b. <b>Atherosclerotic Heart Disease</b> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										immediate years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 					29c. License number <b>D15333</b>			29d. Date signed (Month, Day, Year) <b>1/14/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Thomas G. Johnson 311 N. Fourth St., Oakland, MD 21550</b>											
31. Date filed (Month, Day, Year) <b>FEB - 9 1999</b>		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04678

Amend. 20b, 20c 2/5/99 SM AACO Health

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS BISHOP

2. Date of Death

JAN. 31, 1999

3. Time of Death

8:05PM

4a. Facility Name (If not institution, give street and number)

GENESIS ELDER CARE SPA CREEK

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

068 22 2034

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JAN. 20, 1926

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1204 OAK HILL PLACE APT. 1-B

10f. Zip Code

21403

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PROGRAM MANAGER

16b. Kind of Business/Industry

NON - PROFIT ORG.

17. Father's Name (First, Middle, Last)

EDWARD JOHN ALYANAK

18. Mother's Name (First, Middle, Maiden Surname)

ALICE CONSTANT

19a. Informant's Name/Relationship (Type, Print)

CORNELIA B. STINCHCOMB (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

211 HIGH VIEW DRIVE BOULDER, CO. 80304

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematorium, or other place)

Metropolitan FT. LINCOLN CREMATORY

Date

2/3/99

20c. Location - City or Town, State

Alexandria, VA

~~02-04-99 BRENTWOOD, MD.~~

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOHN M. TAYLOR FUNERAL HOME, INC.  
147 DUKE OF GLOUCESTER ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

METASTATIC BRAIN TUMOR

3-6 mos.

Due to (or as a consequence of):

b.

LUNG CA

&gt; 6 mos.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORD - EMPHYSEMA

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20142

29d. Date signed (Month, Day, Year)

2/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.D. KRAMERS

700 ALLEGATE RD

MANASSAS MD 20108

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

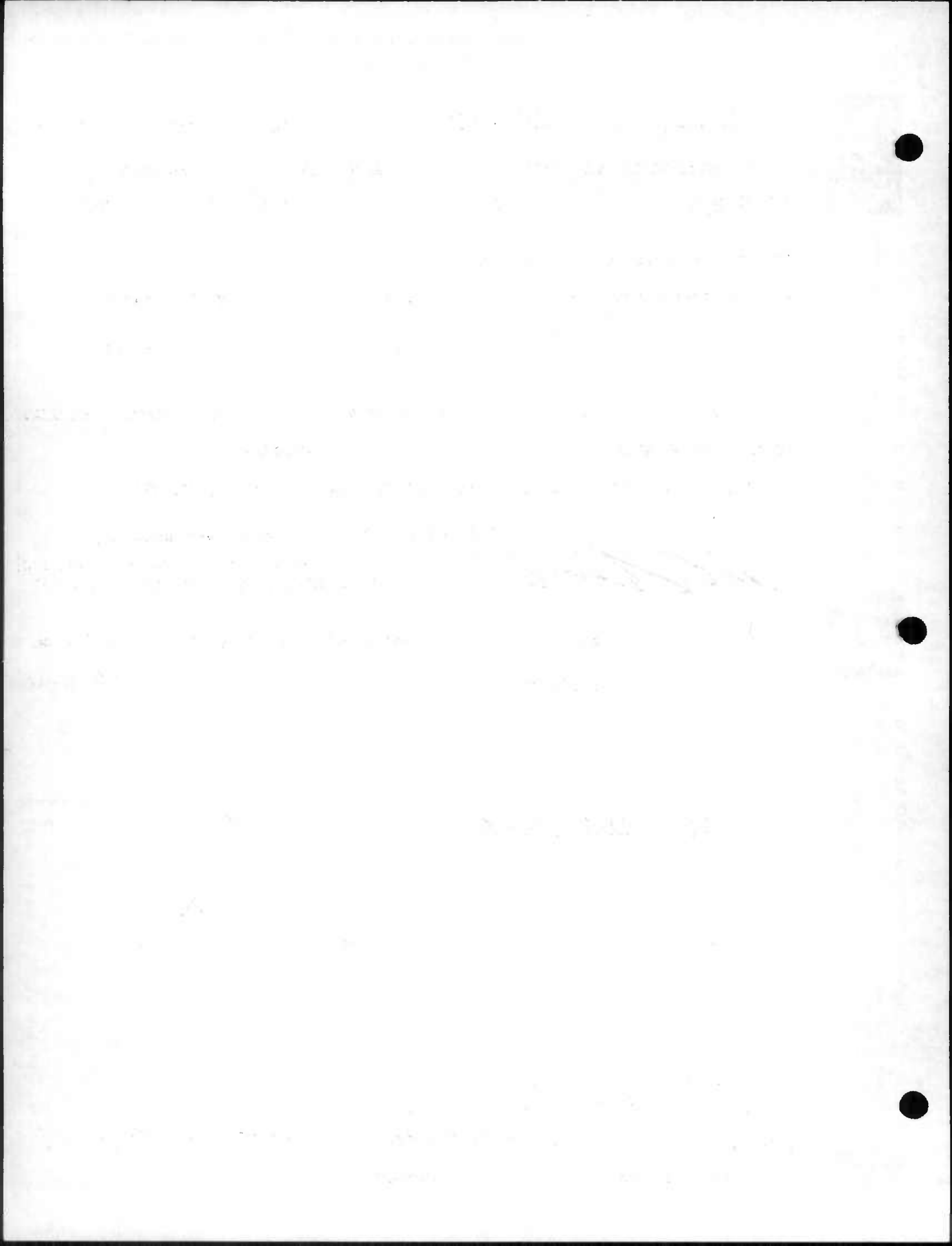
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 04679

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY C. BRADY

2. Date of Death

February 2, 1999

3. Time of Death

12:45 P.M.

4a. Facility Name (If not institution, give street and number)

361 Polling House Road

4b. City, Town, or Location of Death

harwood

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

216-22-3372

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 28, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Harwood

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

361 Polling House Road

10f. Zip Code

20776

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Vincent DePaul Clarke

18. Mother's Name (First, Middle, Maiden Surname)

Ada Carrick

19a. Informant's Name/Relationship (Type, Print)

Joseph B. Brady, Sr./ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

361 Polling House Road Harwood, MD 20776

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lakemont Mem'l. Gardens

Date

2-5-99

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. LUNG CANCER, NON SMALL CELL.

4 mo

Due to (or as a consequence of):

b. CHRONIC CIGARETTE SMOKING

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D05158

29d. Date signed (Month, Day, Year)

FEB 3 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

HARVEY J. STEINFELD

6131 SHADY SIDE RD  
SHADY SIDE, MD 20764

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Amend. 18 2/3/99 SM AACO Health

99 04680

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDWARD CHARLES BURNHAM</b>				2. Date of Death Month Day Year <b>JANUARY 20 1999</b>		3. Time of Death <b>12<sup>30</sup> AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>THE JOHN'S HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>212-26-4259</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar 28, 1929</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1061 Lido Drive</b>		10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant</b>		16b. Kind of Business/Industry <b>U.S. Government</b>				
17. Father's Name (First, Middle, Last) <b>Frank Burnham</b>				18. Mother's Name (First, Middle, Maiden Surname) <del>Marie Emery</del> <b>Marie Emery</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Betty Lou Burnham / wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1061 Lido Drive, Annapolis, MD 21401</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Cemetery</b>		20c. Location - City or Town, State <b>Glen Burnie, MD</b>		20d. Date <b>Feb 1 1999</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. HEAD TRAUMA</b> Due to (or as a consequence of): <b>b. BIPRONTAL HEAD CONTUSION</b> Due to (or as a consequence of): <b>c. VENTILATORY DEPENDENCE</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>2 weeks</b> <b>2 weeks</b> <b>2 weeks</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>JANUARY 10 1999</b>		28b. Time of injury <b>10 A M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred <b>SLIPPED ON ICE, HITTING HEAD</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Residence</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1061 Lido Dr</b>				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 20 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN'S HOPKINS HOSPITAL 600 North Wolfe Street BALTIMORE MARYLAND 21287</b>								
31. Date filed (Month, Day, Year) <b>FEB 03 1999</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04681

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Theresa Bucolo				2. Date of Death Month Day Year January 31, 1999		3. Time of Death 7:25 AM		
	4a. Facility Name (If not institution, give street and number) Crofton Convalescent & Rehabilitation Center				4b. City, Town, or Location of Death Crofton		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 112-30-4437		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 11, 1938		
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Edgewater		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 319 Cedar Grove Road		10f. Zip Code 21037		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) 12th	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier		16b. Kind of Business/Industry Giant Food Stores		17. Father's Name (First, Middle, Last) George Busch		18. Mother's Name (First, Middle, Maiden Surname) Anna Speber		19a. Informant's Name/Relationship (Type, Print) Theodore A. Bucolo/ Husband	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 Cedar Grove Road Edgewater, Maryland 21037		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery		20c. Location - City or Town, State 2-3-99 Annapolis, Maryland		21. Signature of Funeral Service Licensee 	
22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Dehydration Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 1 day		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier MD		29c. License number D 38958		29d. Date signed (Month, Day, Year) February 1, 1999	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DALJEET SINGH SIDHU 1413 ANNAPOLIS ROAD #106 ODENTON MD 21113		31. Date filed (Month, Day, Year) FEB 02 1999		32. Registrar's Signature 		33. Registrar's Title B. Sparks		34. Registrar's Office B. Sparks	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

100



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 04682

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LYDA CASSANDRA COLE</b>					2. Date of Death Month Day Year <b>February 8, 1999</b>		3. Time of Death <b>0700</b>
	4a. Facility Name (If not institution, give street and number) <b>Laurelwood Nursing Center</b>					4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>
Funeral Director	5. Social Security Number <b>221-07-2724</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>November 4, 1906</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Cecil</b>	10c. City, Town or Location <b>Elkton</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>100 Laurel Drive</b>			10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Secretary</b>			16b. Kind of Business/Industry <b>US Government Veterans Hospital</b>		
	17. Father's Name (First, Middle, Last) <b>William E. Walbeck</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ada V. Giffin</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Charles E. Cole / Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12 Colonial Circle, North East, MD 21901</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>North East Methodist Cem.</b>		Date <b>Feb. 10 1999</b>		20c. Location - City or Town, State <b>North East, Maryland</b>	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Crouch Funeral Home 127 South Main Street, North East, MD 21901</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Heart disease</b> Due to (or as a consequence of): <b>b. with Supraventricular Tachycardia</b> Due to (or as a consequence of): <b>c. Chr UTI with urosepsis</b> Due to (or as a consequence of): <b>d. Severe Dementia progressive</b>							Approximate Interval Between Onset and Death <b>10 years</b> <b>3 weeks</b> <b>3 years</b> <b>5 years</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus -</b> <b>Dehydration</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D22307</b>		29d. Date signed (Month, Day, Year) <b>2/8/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>123 Singery Ave - ELKTON, MD 21921</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>FEB 09 1999</b>		32. Registrar's Signature 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04683

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ella Mae Coverdale				2. Date of Death Month Day Year February 5, 1999		3. Time of Death 2007 P	
	4a. Facility Name (If not institution, give street and number) Union Hospital				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil	
Funeral Director	5. Social Security Number 215-12-1808		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) July 10, 1918	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Cecil		10c. City, Town or Location Elkton	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 108 Hilltop Road		10f. Zip Code 21921		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Head Cook		16b. Kind of Business/Industry Cecil County Board of Education				
17. Father's Name (First, Middle, Last) Charles Cecil Brown				18. Mother's Name (First, Middle, Maiden Surname) Josephine Richardson Cox				
19a. Informant's Name/Relationship (Type, Print) Willis James Coverdale, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Hilltop Road, Elkton, Maryland 21921				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State Cedar Hill, Maryland		20d. Date February 9, 1999		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921				
23a. Part I. Enter the disease, or condition, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): b. End Stage Renal Disease Due to (or as a consequence of): c. Diabetes Mellitus Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number D0053034		29d. Date signed (Month, Day, Year) 2/6/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marc Scheiner, MD 223 West Main Street, Elkton, Maryland 21921								
31. Date filed (Month, Day, Year) FEB 08 1999		32. Registrar's Signature 						

To Be Completed by Funeral Director

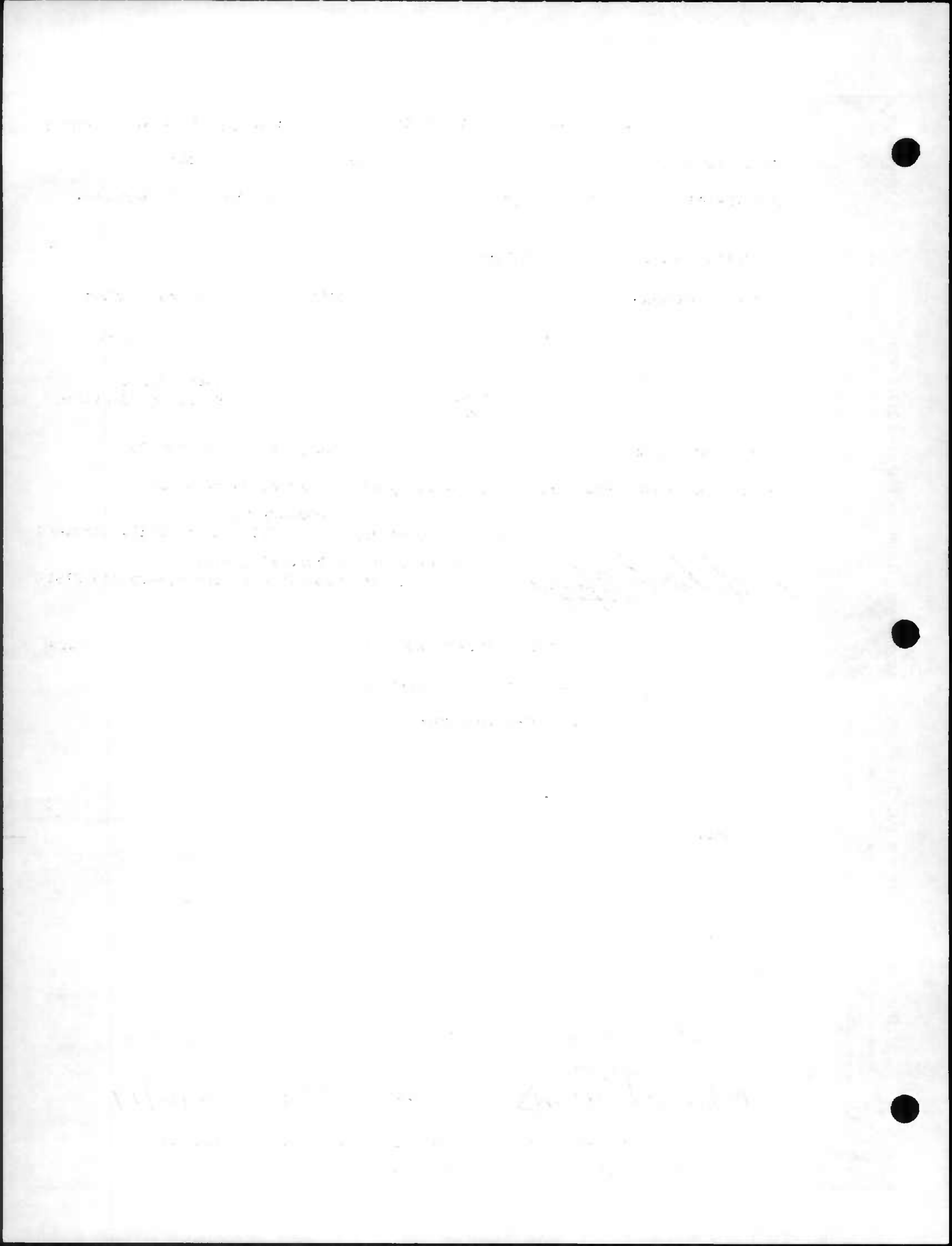
To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04684

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John H. CORDILL SR.</b>				2. Date of Death Month <b>FEB</b> Day <b>2</b> Year <b>1999</b>		3. Time of Death <b>14:48</b>	
	4a. Facility Name (If not institution, give street and number) <b>#40 COX LANE</b>				4b. City, Town, or Location of Death <b>ELKTON</b>		4c. County of Death <b>CECIL</b>	
Funeral Director	5. Social Security Number <b>227-10-1674</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MARCH 9, 1909</b>	
	9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>		10a. State <b>MARYLAND</b>		10b. County <b>CECIL</b>		10c. City, Town or Location <b>ELKTON</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>#40 COX LANE</b>		10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COAL MINER</b>		16b. Kind of Business/Industry <b>MINES</b>		17. Father's Name (First, Middle, Last) <b>CHARLES CORDILL</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH TURNER</b>		19a. Informant's Name/Relationship (Type, Print) <b>MARY R. CORDILL - WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>PO BOX 474 ELKTON MD. 21921</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>NORTHEAST METHODIST</b>		20c. Date <b>2/6/99</b>		20d. Location - City or Town, State <b>NORTHEAST MD.</b>		21. Signature of Funeral Service Licensee <b>Edward H. McKown</b>	
	22. Name and Address of Facility <b>GEE FUNERAL HOME 259 E. MAIN ST. ELKTON MD</b>		23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>RENAL FAILURE</b> Due to (or as a consequence of): b. <b>CARCINOMA PROSTATE</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>107 min.</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how Injury occurred		28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier <b>Robert L. Gray</b>		29c. License number <b>DO1858</b>		29d. Date signed (Month, Day, Year) <b>2/4/99</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ROBERT L. GRAY MD 204 SOUTH ST ELKTON MD.</b>	
State Registrar	31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature <b>James B. Sparks</b>		33. Date of Death (Month, Day, Year) <b>FEB 2 1999</b>		34. Time of Death <b>14:48</b>	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04685

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NANCY CLARK</b>				2. Date of Death Month <b>02</b> Day <b>02</b> Year <b>99</b>		3. Time of Death <b>1635</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-34-0611</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 7, 1937</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Riverdale</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>6305 61st Place</b>				10f. Zip Code <b>20737</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Arthur R. Marion</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Viola Dove</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Sherri L. Williams - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6301 61st Avenue, Riverdale, Maryland 20737</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Date <b>02/05/99</b>		20c. Location - City or Town, State <b>Suitland, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial Infarction</b> Due to (or as a consequence of): <b>b. Renal Failure</b> Due to (or as a consequence of): <b>c. Liver Failure</b> Due to (or as a consequence of): <b>d. Hypertension C</b>  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>48 hrs</b> <b>2 weeks</b> <b>1 year</b> <b>60 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dilated Cardiomyopathy</b> <b>History of Myocardial Infarction</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>P11431</b>		29d. Date signed (Month, Day, Year) <b>2/2/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dablin S. Wasfi M.D. 22 S. Greene St. Baltimore MD 21201</b>								
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04686

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) William F. Caffee, Sr.				2. Date of Death Month Day Year 02/02/99		3. Time of Death 16:02	
4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma		4c. County of Death Montgomery	
5. Social Security Number 415-07-8669		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6/12/19	
9. Birthplace (State or Foreign Country) Rodgersville, TN							
Usual Residence of Decedent							
10a. State DC		10b. County N/A		10c. City, Town or Location Washington		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 900 G St. NE #302				10f. Zip Code 20002		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th 4 yrs.				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chef		16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Franklin Caffee				18. Mother's Name (First, Middle, Maiden Surname) Alice Caffee			
19a. Informant's Name/Relationship (Type, Print) Angela Moore (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 G St. NE, #722, Washington, DC 20002			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cem.		Date 2/8/99		20c. Location - City or Town, State Suitland, MD	
21. Signature of Funeral Service Licensee Edward M. Dudley				22. Name and Address of Facility Dudley Funeral Home 3200 Rhode Island Ave., Mt. Rainier, MD 20712			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ARTERIOSCLEROTIC CARDIOVASCULAR Disease years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Stage IV Sacral decubitus						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Dr. [Signature]				29c. License number D01852		29d. Date signed (Month, Day, Year) FEBRUARY 3 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL A. DEVORE MD 4203 QUEENSBURY RD HYATTSVILLE MD 20781							
31. Date filed (Month, Day, Year) FEB 05 1999				32. Registrar's Signature [Signature]			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

1980 2 0 637

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04687

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kevin Lamont Chase</b>				2. Date of Death Month <b>JAN.</b> Day <b>28</b> , Year <b>1999</b>				3. Time of Death <b>2027 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>PRINCE GEORGES HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>CHEVERLY</b>				4c. County of Death <b>PRINCE GEORGES</b>		
Funeral Director	5. Social Security Number <b>216-92-4003</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>20</b> Yrs.		8. Date of Birth Month <b>November</b> Day <b>15</b> , Year <b>1978</b>		9. Birthplace (State or Foreign) <b>Maryland</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Seabrook</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>9700 Linwood Avenue</b>				10f. Zip Code <b>20706</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Courier</b>				16b. Kind of Business/Industry <b>Lawyers Couriers</b>			
17. Father's Name (First, Middle, Last) <b>Andrew L. Chase</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Brenda Chase</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Andrew L. Chase (Father)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9700 Linwood Avenue Seabrook, Maryland 20706</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Asbury UM Church Cemetery</b>		Date <b>2/4/99</b>		20c. Location - City or Town, State <b>Brandywine, Maryland</b>			
21. Signature of Funeral Service Licensee <i>Alpey J. Walker</i>				22. Name and Address of Facility <b>Rollins Funeral Home, Inc.</b> <b>4339 Hunt Place, N.E. Washington, D.C. 20019</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Multiple Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>1/28/99</b>		28b. Time of Injury <b>1925 P<sup>M</sup></b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>passenger in motor vehicle accident</b>	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>street</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>PG-Cheverly, Md</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <i>Dennis J. Chute, MD</i>				29c. License number <b>O.C.M.E</b>				29d. Date signed (Month, Day, Year) <b>JAN. 29, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>				32. Registrar's Signature <i>B. Jones</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

247



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04688

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES EDWIN COWELL

2. Date of Death

Month Day Year  
JANUARY 27, 1999

3. Time of Death

4:45 P.M.

4a. Facility Name (If not institution, give street and number)

MAGNOLIA GARDENS NURSING CENTER

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

210-18-8287

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN. 2, 1926

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

HYATTSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6109 39TH PLACE

10f. Zip Code

20782

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SALES PERSON

16b. Kind of Business/Industry

INSURANCE

17. Father's Name (First, Middle, Last)

CHARLES COWELL

18. Mother's Name (First, Middle, Maiden Surname)

LEAH TOMB

19a. Informant's Name/Relationship (Type, Print)

RICKY L. COWELL, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6109 39TH PLACE, HYATTSVILLE, MARYLAND 20782

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

FORT LINCOLN CREMATORY

Date

1/30/99

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME

3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. BRONCHOGENIC CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida  
4 ☐ Homicida 5 ☐ Pending  
investigation 6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury


M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D01852

29d. Date signed (Month, Day, Year)

JANUARY 29, 1999

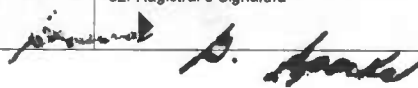
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PAUL A. DeVORE, M.D., 4203 QUEENSBURY ROAD, HYATTSVILLE, MARYLAND 20781

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04689

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD COLNER

2. Date of Death  
Month Day Year  
Jan. 31, 1999

3. Time of Death  
10:30PM

4a. Facility Name (If not institution, give street and number)

2202 Sherbrook Way

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

523-56-6872

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 24 1942

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2202 Sherbrook Way

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Computer Programmer

16b. Kind of Business/Industry

Wang Global

17. Father's Name (First, Middle, Last)

Bernard Colner

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Marcus

19a. Informant's Name/Relationship (Type, Print)

Todd Colner/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2202 Sherbrook Way, Rockville, MD 20850

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King David Cemetery

Date

2/2/99

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Ives Pearson Funeral Home

2847 Wilson Blvd., Arlington, VA 22201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

METASTATIC CUTANEOUS MELANOMA

Approximate Interval Between Onset and Death

6 YEARS

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D07285

29d. Date signed (Month, Day, Year)

FEBRUARY 1, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JAMES A. BROWN MD 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MD

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

*[Signature]*

20850

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04690

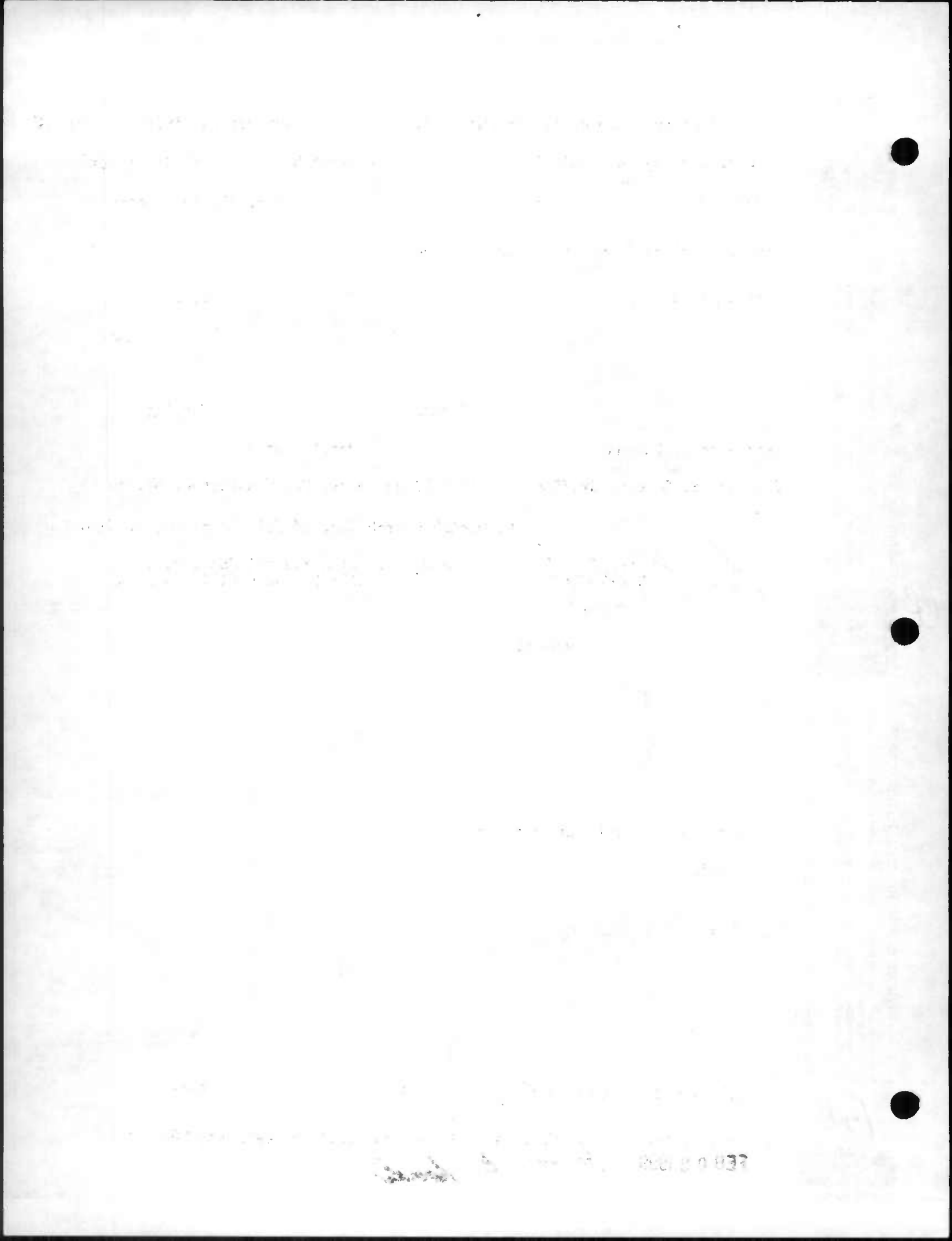
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Theodore Roosevelt Coleman, Sr.				2. Date of Death Month Day Year January 30, 1999		3. Time of Death 10:00 P.M.	
	4a. Facility Name (If not institution, give street and number) Fort Washington Hospital				4b. City, Town, or Location of Death Fort Washington		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 240-01-2800		6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 23, 1902	9. Birthplace (State or Foreign Country) Georgia
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Fort Washington			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 12105 Lihou Court				10f. Zip Code 20744		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer			16b. Kind of Business/Industry Farming	
17. Father's Name (First, Middle, Last) Alexander C. Coleman				18. Mother's Name (First, Middle, Maiden Surname) Mozel Lacey				
19a. Informant's Name/Relationship (Type, Print) Theodore S. Coleman, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12105 Lihou Court, Ft. Washington, MD. 20744				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Mariah Church Cem. 2/6/99		20c. Location - City or Town, State Jackson, S. Carolina		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, MD 20745				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Renal Insufficiency Dementia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D37066		29d. Date signed (Month, Day, Year) 01-31-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uchechi T. Opaigbeogu, M.D. 4467 Old Branch Ave. #105, Temple Hills, MD 20748								
31. Date filed (Month, Day, Year) FEB 02 1999				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04691

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CARL COLUMBUS COFFMAN, JR.						2. Date of Death Month Day Year FEBRUARY 3 1999		3. Time of Death 9:20 AM														
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL						4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY														
Funeral Director	5. Social Security Number 233-34-3115		6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 30 1923		9. Birthplace (State or Foreign Country) OHIO														
	Usual Residence of Decedent																						
10a. State MARYLAND			10b. County ALLEGANY			10c. City, Town or Location CUMBERLAND			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
10e. Street and Number 410 WEMPE DRIVE						10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.															
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW11			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OPERATING ENGINEERS LOCAL			16b. Kind of Business/Industry ENGINEERS														
17. Father's Name (First, Middle, Last) CARL COLUMBUS COFFMAN SR						18. Mother's Name (First, Middle, Maiden Summa) FLOYA HOUSE																	
19a. Informant's Name/Relationship (Type, Print) BETTY LOU COFFMAN WIFE						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 WEMPE DRIVE CUMBERLAND MARYLAND 21502																	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) FAIRVIEW CHRISTIAN CEMT. FEB 6 1999				20c. Location - City or Town, State INGLESMTIH PA.															
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND																	
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																							
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>ACUTE RESPIRATORY FAILURE</td> <td>72 hours</td> </tr> <tr> <td>b.</td> <td>PNEUMONIA WIDESPREAD</td> <td>72 hours</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td>NON-SMALL CELL CARCINOMA LUNG</td> <td>8/98</td> </tr> </table>											Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	ACUTE RESPIRATORY FAILURE	72 hours	b.	PNEUMONIA WIDESPREAD	72 hours	c.			d.	NON-SMALL CELL CARCINOMA LUNG	8/98
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	ACUTE RESPIRATORY FAILURE	72 hours																				
	b.	PNEUMONIA WIDESPREAD	72 hours																				
	c.																						
	d.	NON-SMALL CELL CARCINOMA LUNG	8/98																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																							
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide																							
28a. Date of Injury (Month, Day Year)			28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred																
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																							
29b. Signature and title of certifier 						29c. License number D 23371		29d. Date signed (Month, Day, Year) Feb 4, 1999															
30. Name and address of person who completed cause of death (item 23e) (Type, Print) QAMAR ZAMAN M.D., 625 JOHNSON HEIGHTS MEDICAL BLDG., CUMBERLAND, MD 21502																							
31. Date filed (Month, Day, Year) FEB 05 1999																							
32. Registrar's Signature 																							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CARL COFFMAN 233-34-3115

Division of Vital Records, P.O. Box 68760,

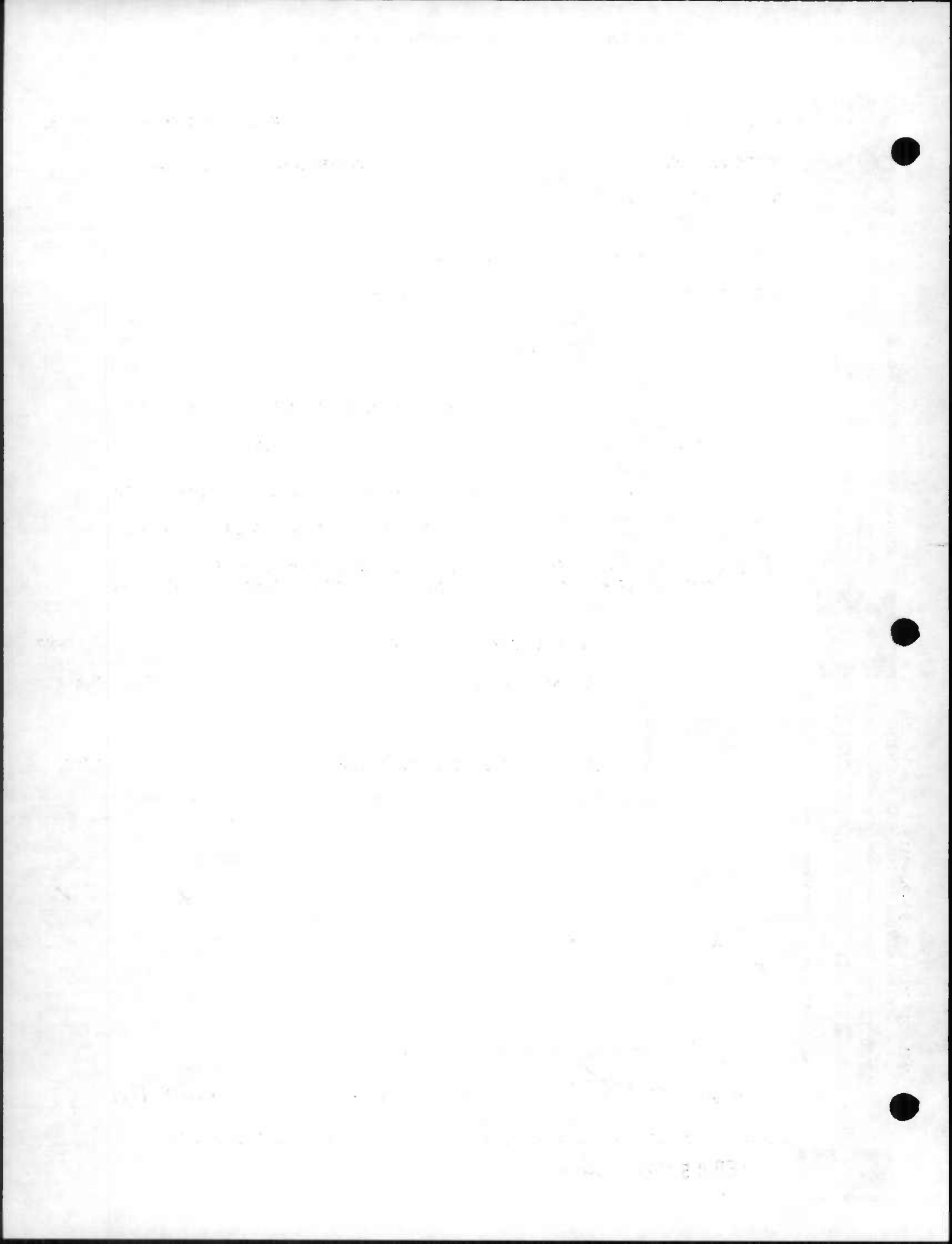
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Amended # 22  
Allegany County  
2/6/99 mlv

Amended  
#95  
10A, 10B,  
10C, 10E + 10F  
Allegany County 2/12/99 mlf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04692

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>ANNA MAE COOK</b>		2. Date of Death Month <b>FEBRUARY</b> Day <b>6</b> Year <b>1999</b>		3. Time of Death <b>845 am</b>	
4a. Facility Name (If not institution, give street and number) <b>10216 Greenwood Lane</b>		4b. City, Town, or Location of Death <b>Ellerslie</b>		4c. County of Death <b>Allegany</b>	
5. Social Security Number <b>216 14 1447</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>2-24-18</b>		9. Birthplace (State or Foreign Country) <b>MD</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Ellerslie Bradenton</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3405 Southern PARKWAY West</b>		10f. Zip Code <b>21529 34205-2944</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>		17. Father's Name (First, Middle, Last) <b>Norman L. Cook</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Mary Newman</b>		19a. Informant's Name/Relationship (Type, Print) <b>Nial F. Cook/Spouse</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10216 Greenwood Lane, Ellerslie, MD 21529</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cooks Mills Cemetery</b>		20c. Location - City or Town, State <b>2-9-99 Hyndman, PA</b>	
21. Signature of Funeral Service Licensee <b>Harvey H. Zeigler</b>		22. Name and Address of Facility <b>Harvey H. Zeigler Funeral Home, Hyndman, PA</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cerebro-vascular disease</b> Due to (or as a consequence of): <b>Hypertension</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Cerebro-vascular disease</b> Due to (or as a consequence of): b. <b>Hypertension</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>052056</b>	
29d. Date signed (Month, Day, Year) <b>FEBRUARY 8, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANNE MARIE VILLANOSA, MD 925 BISHOP WALK ROAD CUMBERLAND, MD 21502</b>		31. Date filed (Month, Day, Year) <b>FEB 08 1999</b>	
32. Registrar's Signature <b>[Signature]</b>					

State  
Registrar

Received by J. J. Jones



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 04693

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Thelma Cain</b>						2. Date of Death Month Day Year <b>Jan 22 1999</b>		3. Time of Death <b>11:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital</b>						4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>579-16-5288</b>		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sep 26, 1916</b>		9. Birthplace (State or Foreign Country) <b>WV</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>223 Pennsylvania Avenue</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>			
17. Father's Name (First, Middle, Last) <b>Leonard C. Wintermoyer</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Minnie V. (Imes)</b>				
19a. Informant's Name/Relationship (Type, Print) <b>John Cain-son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1206 Lafayette Avenue Cumberland MD 21502</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		Date <b>01/25</b>		20c. Location - City or Town, State <b>Cumberland MD</b>		
21. Signature of Funeral Service Licensee <i>Nicholas J. Scarpelli</i>						22. Name and Address of Facility <b>Scarpelli Funeral Home, P.A. Cumberland MD 21502</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Renal failure</b> Due to (or as a consequence of): <b>a.therosclerosis</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>1 week</b> <b>15 yrs.</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Vik Poonai</i>						29c. License number <b>D 36766</b>		29d. Date signed (Month, Day, Year) <b>January 23, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Vik Poonai, M.D. 920 National Highway, Lavale, Maryland 21502</b>										
31. Date (Month, Day, Year) <b>FEB 02 1999</b>			32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Thelma Cain 579-16-5288

(Scarpelli)

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, the interpretation of the data, and the conclusions drawn from the research.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the research, the strengths of the findings, and the suggestions for further research.

5. The fifth part of the report is a conclusion. It summarizes the main findings of the study and provides a final statement on the significance of the research.

6. The sixth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.

7. The seventh part of the report is an appendix. It includes a list of the tables, figures, and other supplementary material used in the study.

8. The eighth part of the report is a glossary. It includes a list of the terms and abbreviations used in the study.

9. The ninth part of the report is a bibliography. It includes a list of the books, articles, and other sources used in the study.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

09 04694

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Evonne Chamberlain</b>				2. Date of Death Month Day Year <b>Jan 19 1999</b>		3. Time of Death <b>12:01PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
5. Social Security Number <b>179-60-3713</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>22</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>07/03/76</b>	
9. Birthplace (State or Foreign Country) <b>New Hampshire</b>							
10a. State <b>WV</b>		10b. County <b>Morgan</b>		10c. City, Town or Location <b>Paw Paw</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>Winchester Avenue</b>				10f. Zip Code <b>25434</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>student</b>		16b. Kind of Business/Industry <b>school</b>	
17. Father's Name (First, Middle, Last) <b>Michael C. Chamberlain, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Donna Twigg</b>			
19a. Informant's Name/Relationship (Type, Print) <b>mother - Donna Twigg</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. Box 61, Paw Paw, WV 25434</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Camp Hill Cemetery</b>		Date <b>01/23/99</b>		20c. Location - City or Town, State <b>Paw Paw WV</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Fraleay-Kimble Funeral Home</b> <b>501 Henry W. Miller Hwy. Paw Paw, WV 25434</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Down's syndrome with complications</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>Dpty Med Ex</b>					
		29c. License number <b>D 09157</b>		29d. Date signed (Month, Day, Year) <b>Jan 19 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Snow, M.D. 124 w 3rd st Cumb., Md 21502</b>							
31. Date filed (Month, Day, Year) <b>FEB 03 1999</b>		32. Registrar's Signature 					

State  
Registrar



Amended # 236, N.H.S.,  
2/5/99, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04695

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONALD JOSEPH CONN				2. Date of Death Month Day Year JANUARY 29, 1999				3. Time of Death 1350						
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND				4c. County of Death ALLEGANY						
Funeral Director	5. Social Security Number 725-09-1414		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 16, 1934		9. Birthplace (State or Foreign Country) MARYLAND						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State MD		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	10e. Street and Number 12203 BEDFORD ROAD, N.E.				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.								
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: KOREA		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER				16b. Kind of Business/Industry RETAIL STORE						
	17. Father's Name (First, Middle, Last) EARL W. CONN				18. Mother's Name (First, Middle, Maiden Surname) ESTHER LOGSDON										
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JAMES L. CONN / BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 137 POLK STREET, CUMBERLAND, MD 21502										
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND ANATOMY BOARD		Date 1/30/99		20c. Location - City or Town, State BALTIMORE, MD						
	21. Signature of Funeral Service Licensee <i>Sherry A. Upchurch</i>				22. Name and Address of Facility MARYLAND ANATOMY BOARD 655 W. BALT. ST. - BALTIMORE, MD 21201										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Respiratory failure 2: to 24 h</i> <i>End stage Ca lung 24 3 years</i>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier <i>U. Velandia M.D.</i>		29c. License number D08377		29d. Date signed (Month, Day, Year) JANUARY 29, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 Sebn Dr. Cumberland, MD 21502										31. Date filed (Month, Day, Year) FEB 01 1999		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be delivered for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

FEB 01 1966



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04696

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David Robert Coffield, Sr.

2. Date of Death

FEBRUARY 07, 1999

Day Year

3. Time of Death

3:00 P.M.

4a. Facility Name (If not institution, give street and number)

MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death

CAMP SPRINGS

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

236 42 8399

6. Sex

1X M 2 F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 13, 1925

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Camp Springs,

10d. Inside City Limits

1 Yes 2X No

10e. Street and Number

6102 Davis Blvd

10f. Zip Code

20746

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2X Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1X Yes 2 No  
If Yes, Give Year or Dates: 1921

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
1

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired U.S. Airforce

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

David Wilbert Coffield

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Frazier

19a. Informant's Name/Relationship (Type, Print)

Berneice Coffield (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6102 Davis Blvd, Camp Springs, MD 20746

20a. Method of Disposition

1X Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery

Feb 11, 1999

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC NEUTROPHILIC LEUKEMIA

Due to (or as a consequence of):

UNKNOWN

c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

UNKNOWN

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1X Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2X No

25. Was case referred to medical examiner?

1 Yes 2X No

Hospital:

1X Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1X Natural 5 Pending Investigation  
2 Accident 6 Could not be determined  
3 Suicide  
4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

  
STAFF Internal Medicine

29c. License number

MD-058405-L-PA

29d. Date signed (Month, Day, Year)

FEBRUARY 07, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALAN PERLMAN, CAPT, USAF, MC

89 MDG/ 1050 W PERIMETER RD  
ANDREWS AIR FORCE BASE, MD 20762-6600

31. Date filed (Month, Day, Year)

FEB 09 1999

32. Registrar's Signature

State  
RegistrarNAME: DAVID COFFIELD  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

1041





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Benjamin Wilson Cochrane

2. Date of Death  
Month Day Year

February 4 1999

3. Time of Death

1045 PM

4a. Facility Name (If not institution, give street and number)

6074 Macs Hollow Road

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

219 07 2059

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

June 6 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6074 Macs Hollow Road

10f. Zip Code

20678

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

heavy equipment operator

16b. Kind of Business/Industry

construction

17. Father's Name (First, Middle, Last)

Cephas Wilburn Cochrane

18. Mother's Name (First, Middle, Maiden Surname)

Nanny Williams

19a. Informant's Name/Relationship (Type, Print)

Betty L. Cochrane- wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6074 Macs Hollow Rd. Prince Frederick MD 20678

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Feb 8 99  
MT. Harmony Cemetery

Date

20c. Location - City or Town, State

Owings Maryland

21. Signature of Funeral Service Licensee

B Bausch

22. Name and Address of Facility

Rausch Funeral Home PA

4405 Broomes Is. Rd. Port Republic MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Endstage Ischemic Cardiovascular

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B Bausch

29c. License number

033123

29d. Date signed (Month, Day, Year)

2-5-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Cowen L, MD, 110 Hospital Rd, Ste 310, Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04698

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Francis Cavey</b>				2. Date of Death Month <b>JAN.</b> Day <b>28,</b> Year <b>1999</b>		3. Time of Death <b>12:00 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL</b>				4b. City, Town, or Location of Death <b>GLEN BURNIE</b>		4c. County of Death <b>ANNE ARUNDEL</b>		
Funeral Director	5. Social Security Number <b>213-20-7743</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 22, 1908</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>419 Carroll Court</b>			10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security Guard</b>			16b. Kind of Business/Industry <b>Westinghouse Defense Contractor</b>			
	17. Father's Name (First, Middle, Last) <b>Emslie Cavey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Clara Hohman</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>William Cavey, Jr. / son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>419 Carroll Court, Glen Burnie, MD 21061</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Park</b>		Date <b>Feb 1 1999</b>		20c. Location - City or Town, State <b>Elkridge, MD</b>		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home</b> <b>495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <i>Chest Injuries</i></b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b><i>Atherosclerotic Cardiovascular Disease</i></b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>11/28/99</b>		28b. Time of Injury <b>1136 A</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>motor vehicle accident</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JAN. 29, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis G. Chute 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>FEB 03 1999</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



99 04699

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Curtis Clay Dunn</b>				2. DATE OF DEATH MONTH DAY YEAR <b>February 1, 1999</b>		3. TIME OF DEATH <b>11:10 A M</b>	
4. SOCIAL SECURITY NUMBER <b>410-34-1612</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>73</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>August 29, 1925</b>		8. BIRTHPLACE (State or Foreign Country) <b>Tennessee</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>22 Augusta Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Elkton</b>		9c. COUNTY OF DEATH <b>Cecil</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Tennessee</b>		10b. COUNTY <b>Johnson</b>		10c. CITY, TOWN OR LOCATION <b>Mountain City</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1104 Eastridge Road</b>				10f. ZIP CODE <b>37683</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self-employed Truck Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Transportation</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Dunn</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha Pope</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ruby Dunn/ Wife</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1104 Eastridge Road, Mountain City, Tennessee 37683</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Union Cemetery</b>		20c. LOCATION — City or Town, State <b>Union, Maryland</b>		20d. DATE <b>February 5, 1999</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James S. Hicks</i>				22. NAME AND ADDRESS OF FACILITY <b>Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Non Small Cell Lung Cancer</b>				Approximate Interval Between Onset and Death <b>3 months</b>	
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>H. Farkas, MD</i>				29c. LICENSE NUMBER <b>D15314</b>		29d. DATE SIGNED (Month, Day, Year) <b>February 2, 1999</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>H Farkas, MD VNA/Northern Chesapeake Hospice, Elkton, MD</b>							
31. DATE FILED (Month, Day, Year) <b>FEB 04 1999</b>				32. REGISTRAR'S SIGNATURE <i>Geneva B. Sparks</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.









Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04701

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>ALMA NEVA DEAN</b>						2. Date of Death Month Day Year <b>FEBRUARY 2, 1999</b>		3. Time of Death <b>10:10 p.m.</b>	
4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL &amp; MEDICAL CENTER</b>						4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
5. Social Security Number <b>220-10-9169</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN 16 1918</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
Usual Residence of Decedent									
10a. State <b>MARYLAND</b>		10b. County <b>ALLEGANY</b>		10c. City, Town or Location <b>CUMBERLAND</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>29 MAPLE STREET</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSE WIFE</b>			16b. Kind of Business/Industry <b>HOUSE WIFE</b>		
17. Father's Name (First, Middle, Last) <b>THEODORE KIDWELL</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MARTHA RUDY</b>			
19a. Informant's Name/Relationship (Type, Print) <b>JUNE ZEMBOWER DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>551 PINE RIDGE ROAD BEDFORD PA. 15522</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOODROW CEMETERY FEB 6 1999</b>			20c. Location - City or Town, State <b>PAW PAW, WEST VIRGINIA</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARCINOMA, BREAST WITH BONE METASTASIS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____ Due to (or as a consequence of):</b> <b>c. _____ Due to (or as a consequence of):</b> <b>d. _____ Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>2 years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number <b>D 14865</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 5, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBUSTIANO J. BARRERA, M.D. MEMORIAL MEDICAL BLDG. STE. 201 CUMBERLAND, MD 21502</b>									
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>				32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DEAN, ALMA

220-10-9169

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04702

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William James Devlin					2. Date of Death Month Day Year FEBRUARY 1, 1999		3. Time of Death 2035		
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital					4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany		
Funeral Director	5. Social Security Number 216-07-2741		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) March 12 1912		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
10a. State MD		10b. County Allegany		10c. City, Town or Location Lonaconing				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 9 High Street					10f. Zip Code 21539		10g. Citizen of What Country? USA			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Miner			16b. Kind of Business/Industry Coal			
17. Father's Name (First, Middle, Last) Terance Devlin					18. Mother's Name (First, Middle, Maiden Surname) Nannie Symons					
19a. Informant's Name/Relationship (Type, Print) Bernadette Brown sister					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 High Street, Lonaconing, MD 21539					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) St. Marys Cemetery			20c. Location - City or Town, State Feb. 4 1999 Lonaconing, MD				
21. Signature of Funeral Service Licensee James E. McKenzie					22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 E. Main Street, Lonaconing, MD 21539					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Embolism Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death 15 minutes	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recent Transurethral Resection of Prostate Hypertrophy Old Right Deep Vein Thrombosis of Right Leg. Parkinson's Disease							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier S. Changin D.			29c. License number D 25638		29d. Date signed (Month, Day, Year) FEBRUARY 3, 1999		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SATURNIA CHAN, M.D. Rt 36 Fronting Plaza Frostburg Maryland 21532										
31. Date filed (Month, Day, Year) FEB 05 1999			32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Amended #5  
Allegany County mlu  
2/10/99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04703

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

MILDRED DURST 213-24-5015  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

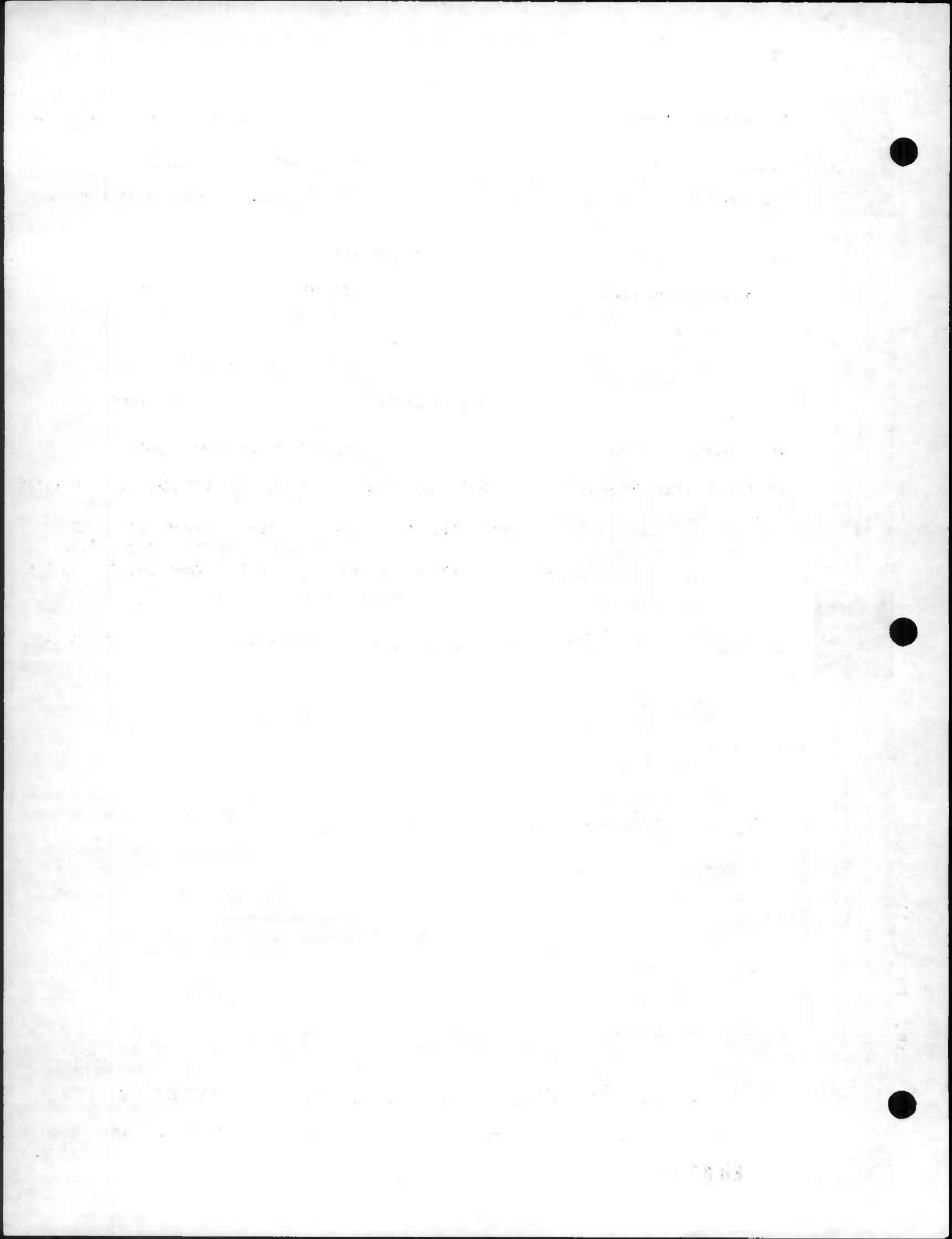
Physician  
/Medical  
Examiner

Funeral  
Director

State  
Registrar

1. Decedent's Name (First, Middle, Last) <b>Mildred Mae Durst</b>		2. Date of Death Month Day Year <b>JANUARY 28 1999</b>		3. Time of Death <b>12:26 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
5. Social Security Number <b>212-24-5015</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Aug. 9, 1927</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>			
10a. State <b>MD</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Grantsville</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>22 Dorsey Hotel Road</b>		10f. Zip Code <b>21536</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self-employed</b>		16b. Kind of Business/Industry <b>Ledgestone</b>	
17. Father's Name (First, Middle, Last) <b>Earl Thomas Frickey</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Katherine Broadwater</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Willis E. Durst/Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>22 Dorsey Hotel Rd, PO Box 92, Grantsville, MD 21536</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Grantsville Cem., Jan. 31, 1999</b>		20c. Location - City or Town, State <b>Grantsville, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Newman Funeral Homes, P.A. 179 Miller St., PO Box 275, Grantsville, MD 21536</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Decompensated COPD</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>		Approximate Interval Between Onset and Death <b>10 days</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive heart failure Demented</b>		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>DS1654</b>	
29d. Date signed (Month, Day, Year) <b>JANUARY 30, 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Thomas Seale 22 S GREENE ST BALTIMORE MD 21201</b>					
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature 			





amended line  
12, fchd, kb

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04704

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Jeremiah Delaney

2. Date of Death  
Month Day Year  
February 4, 1999

3. Time of Death  
7:35 A.M.

4a. Facility Name (If not institution, give street and number)

6607 Rockridge Road

4b. City, Town, or Location of Death

New Market

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

572-38-0281

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)

Dec 4, 1932

9. Birthplace (State or Foreign  
Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

New Market

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

6607 Rockridge Road

10f. Zip Code

21774

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1949  
1959  
1974

13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Professor

16b. Kind of Business/Industry

Health Administration

17. Father's Name (First, Middle, Last)

Delourie Delaney

18. Mother's Name (First, Middle, Maiden Surname)

Edna Nunnemaker

19a. Informant's Name/Relationship (Type, Print)

Patricia Delaney - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6607 Rockridge Road, New Market, Maryland 21774

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hagerstown Crematory

Date

2-5-99

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensed

*St. Doughs Hunter*

22. Name and Address of Facility

Stauffer Funeral Homes, P. A.  
1621 Opossumtown Pike, Frederick, Maryland 21702

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. B-CELL LYMPHOMA of CENTRAL NERVOUS 6 weeks  
system / BRAIN  
Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury  
(Month, Day Year)

28b. Time of  
Injury

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29e. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*Joseph Ashwal MD*

29c. License number

D26609

29d. Date signed (Month, Day, Year)

4 FEB 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Ashwal, 56 Thomas Johnson Drive, Frederick, MD 21701

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

*Beverly B. Sparks*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04705  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT R.L. EVERLY, I</b>				2. Date of Death Month <b>Feb.</b> Day <b>2,</b> Year <b>1999</b>		3. Time of Death <b>1748</b>	
	4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>214-05-6382</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 7, 1921</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>940 Glenwood Street</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retired</b>		16b. Kind of Business/Industry <b>Railroad</b>		
17. Father's Name (First, Middle, Last) <b>James W. Everly</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lottie A. (Crowfis)</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Lillian G. Everly--wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>940 Glenwood Street; Cumberland, MD 21502</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hillcrest Memorial Park</b>		Date <b>02/05</b>		20c. Location - City or Town, State <b>Cumberland, MD</b>		
21. Signature of Funeral Service Licensee <i>Nicholas J. Scarpelli</i>				22. Name and Address of Facility <b>Scarpelli Funeral Home, P.A. Cumberland, MD 21502</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Severely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  e. <b>Severe Coronary Artery disease</b> Due to (or as a consequence of): b. <b>Severe Pulmonary Hypertension</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>~ years.</b> <b>~ years</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Samir Elia</i>				29c. License number <b>D40693</b>		29d. Date signed (Month, Day, Year) <b>Feb, 5, 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. Samir Elia; 909 B Seton Drive; Cumberland, MD 21502</b>								
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature <i>Samir B. Elia</i>						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04706

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sidney Walter Earle Sr.</b>					2. Date of Death Month <b>Jan.</b> Day <b>31</b> Year <b>1999</b>		3. Time of Death <b>12:30 p.m.</b>			
	4e. Facility Name (If not institution, give street and number) <b>108 Broadway Street</b>					4b. City, Town, or Location of Death <b>Frostburg</b>		4c. County of Death <b>Allegany</b>			
Funeral Director	5. Social Security Number <b>218-20-0302</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 1, 1905</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
	Usual Residence of Decedent					10f. Zip Code <b>21532</b>		10g. Citizen of What Country? <b>United States</b>			
To Be Completed by Funeral Director	10e. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Frostburg</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>108 Broadway</b>					10f. Zip Code <b>21532</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Heating Engineer</b>		16b. Kind of Business/Industry <b>National Geographic Society</b>						
	17. Father's Name (First, Middle, Last) <b>Sidney Morris Earle</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Corkran Earle</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Lillian Earle/daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>108 Broadway st Frostburg MD 21532</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cumberland Crematory</b>		Date <b>2-2-99</b>		20c. Location - City or Town, State <b>Cumberland md</b>				
	21. Signature of Funeral Service Licensee <b>Alan M Sowers</b> MO0547					22. Name and Address of Facility <b>Sowers Funeral Home, P.A. 60 W. Main St. Frostburg, MD 21532</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute and Chronic Congestive Heart Failure</b>					Approximate Interval Between Onset and Death <b>7.5 yrs</b>					
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Piece of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29b. Signature and title of certifier <b>Terry E. Williams M.D.</b>						
29c. License number <b>D16041</b>					29d. Date signed (Month, Day, Year) <b>09-30-99</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Terry E. Williams, M.D., 500 Memorial Avenue, Cumberland, MD 21502</b>											
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>					32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04707

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BERNARD ALEXIS EMERICK, SR.

2. Date of Death

January 29, 1999

3. Time of Death

8:30 am

4a. Facility Name (If not institution, give street and number)

14120 Fenway Avenue

4b. City, Town, or Location of Death

Ellerslie

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

215 34 2569

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

sept 9, 1934

9. Birthplace (State or Foreign Country)

maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Ellerslie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

14120 Fenway Avenue

10f. Zip Code

21529

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1961-63

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bottler

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Charles Leroy Emerick

18. Mother's Name (First, Middle, Maiden Surname)

Anna Elizabeth Ash

19a. Informant's Name/Relationship (Type, Print)

Mary T. Emerick/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. Box 87, Ellerslie, MD 21529

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Palo Alto Cemetery

Date

2-1-99

20c. Location - City or Town, State

Hyndman, PA

21. Signature of Funeral Service Licensee

Harvey H. Zeigler

22. Name and Address of Facility

Harvey H. Zeigler Funeral Home  
Hyndman, PA 15545

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Metastatic Carcinoma of the Colon

Approximate Interval Between Onset and Death

8 weeks

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):  
Due to (or as a consequence of):  
Due to (or as a consequence of):  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier  
Richard H. Snider, MD

29c. License number

D 17246

29d. Date signed (Month, Day, Year)

2/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard L. Snider, MD, Cumberland, MD 21502

31. Date Filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

▶

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04708

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE EDWARD EBLE, JR.					2. Date of Death Month Day Year Feb 04 1999		3. Time of Death 0043 AM																									
	4a. Facility Name (If not institution, give street and number) The Memorial Hospital					4b. City, Town, or Location of Death Easton		4c. County of Death Talbot																									
Funeral Director	5. Social Security Number 214-24-4267		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 27, 1927		9. Birthplace (State or Foreign Country) MARYLAND																								
	Usual Residence of Decedent																																
10a. State MARYLAND		10b. County CAROLINE		10c. City, Town or Location HARMONY				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																									
10e. Street and Number 7049 GARNEY'S WHARF ROAD					10f. Zip Code 21655		10g. Citizen of What Country? USA																										
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-1947		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE																									
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) POLICE OFFICER			16b. Kind of Business/Industry LAW ENFORCEMENT																									
17. Father's Name (First, Middle, Last) GEORGE EDWARD EBLE, SR.					18. Mother's Name (First, Middle, Maiden Surname) MADELINE ZINCAN																												
19a. Informant's Name/Relationship (Type, Print) KATHERINE P. EBLE/WIFE					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7049 GARNEY'S WHARF ROAD, PRESTON, MD 21655																												
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MD. VET. CEM. EASTERN SHORE 2/8		Date		20c. Location - City or Town, State BEULAH, MARYLAND																										
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631																												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Coronary artery disease</td> <td>yrs</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>Hypertension</td> <td>yrs</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td>Diabetes</td> <td>yrs</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="3">d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	Coronary artery disease	yrs	Due to (or as a consequence of):			b.	Hypertension	yrs	Due to (or as a consequence of):			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Diabetes	yrs	Due to (or as a consequence of):			d.			
Immediate Cause (Final disease or condition resulting in death)	a.	Coronary artery disease	yrs																														
	Due to (or as a consequence of):																																
	b.	Hypertension	yrs																														
	Due to (or as a consequence of):																																
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Diabetes	yrs																														
	Due to (or as a consequence of):																																
d.																																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																	
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																																	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																												
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																								
28d. Describe how injury occurred					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																												
28f. Location (Street and Number or Rural Route Number, City or Town, State)																																	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																	
29b. Signature and title of certifier 					29c. License number H0053459		29d. Date signed (Month, Day, Year) 02/04/99																										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David C. Boehmer, 219 S. Washington Street, Easton, MD 21601																																	
31. Date filed (Month, Day, Year) FEB 8 1999					32. Registrar's Signature 																												

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

GEORGE EDWARD EBLE

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04709

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Willie James Franklin

2. Date of Death

January 31, 1999

3. Time of Death

5:15pm

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

256-54-5814

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 13, 1938

9. Birthplace (State or Foreign Country)

Norwood, Ga.

Usual Residence of Decedent

10e. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1612 Q. Street S.E.

10f. Zip Code

20020

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Warehouse Supervisor

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Willie Franklin

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Mays

19a. Informant's Name/Relationship (Type, Print)

Tyrone Franklin/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1612 Q. Street S.E. Washington, D.C. 20020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Resurrection Cemetery

Date

2/5/99

20c. Location - City or Town, State

Clinton, Md.

21. Signature of Funeral Service Licensee

Kent A. Jones 1/10/99

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Md. 20747

Approximate  
Interval Between  
Onset and Death

YEARS

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR

Due to (or as a consequence of):

DISEASE

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HEPATIC ENCEPHALOPATHY

END STAGE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Jones

29c. License number

D-18545

29d. Date signed (Month, Day, Year)

FEB. 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12070 OLD LINE CENTER S-207 Waldorf, Md. 20602

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

A. Jones

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1001 1 6 837



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04710

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BLANCHE M FOSTER</b>				2. Date of Death Month Day Year <b>1/29/99</b>		3. Time of Death <b>2:49PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL</b>				4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PG</b>	
Funeral Director	5. Social Security Number <b>579-24-4263</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth Month Day Year <b>3/12/17</b>	
	9. Birthplace (State or Foreign) <b>NORTH CAROLINA</b>		10a. State <b>MD</b>		10b. County <b>PG</b>		10c. City, Town or Location <b>CAPITOL HEIGHTS</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>1112 ELFIN AVENUE</b>		10f. Zip Code <b>20743</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>BLACK</b> Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YEARS</b>		College (1-4 or 5+) <b>NONE</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>GOVERNMENT EMPLOYEE</b>		16b. Kind of Business/Industry <b>BUREAU OF ENGRAVING &amp; PRINTING</b>		
17. Father's Name (First, Middle, Last) <b>JAMES JONES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SUSIE CLEMMER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>EUNICE JONES (SISTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS 10A,B,C,D,E,&amp;F</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LINCOLN MEMORIAL</b>		Date <b>2/4/99</b>		20c. Location - City or Town, State <b>SUITLAND, MD.</b>		
21. Signature of Funeral Service Licensee <i>Robert L. Plummer</i>		22. Name and Address of Facility <b>JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Congestive Heart Failure</i> Due to (or as a consequence of):  b. <i>Underlying Coronary Artery Disease</i> Due to (or as a consequence of):  c. <i>With Myocardio pathy 20yrs.</i> Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Recent Upper GI Bleed from Gastric Ulcer</i> <i>Advanced Age with general debilitation</i> <i>Insulin Dependent Diabetes (No anemia on CBC)</i>								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Richard A. Farson MD</i>		29c. License number <b>DO 2237 MD</b>		29d. Date signed (Month, Day, Year) <b>1/30/99</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Richard A. Farson MD 12825 Old Fort Rd Fort Wash. MD 20744</i>								
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature <i>A. Farson</i>						

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04711

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dora L. FERGUSON</b>				2. Date of Death Month <b>01</b> Day <b>28</b> Year <b>99</b>		3. Time of Death <b>9:15</b>	
	4a. Facility Name (If not institution, give street and number) <b>Heartland Health Care Center of Adelphi</b>				4b. City, Town, or Location of Death <b>Adelphi</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>228-03-5358</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>96</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>6/13/02</b>	9. Birthplace (State or Foreign Country) <b>Warrenton, N.C.</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>Landover</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1435 Belle Haven Dr.</b>				10f. Zip Code <b>20785</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Thomas Plummer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Powell</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Dorothy Ferguson Bailey/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>500 N. Harry Truman Dr., Landover, Md. 20785</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory, Inc.</b>		20c. Location - City or Town, State <b>1/30/99 Beltsville, Md.</b>		
21. Signature of Funeral Service Licensee <b>Larry H. Charr</b>				22. Name and Address of Facility <b>H.S. Washington &amp; Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 20019</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Advancing Dementia.</b> Due to (or as a consequence of): <b>b. Alzheimer's Disease.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Approximate Interval Between Onset and Death <b>&gt; 10 yrs</b> <b>&gt; 5 yrs</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Complete Heart Block with Pacemaker, Extensive Degenerative Arthritis.</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <b>Stuart Turkewitz, MD</b>				29c. License number <b>D31001</b>		29d. Date signed (Month, Day, Year) <b>1/28/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stuart Turkewitz, MD</b>				<b>2500 Greenway Ctr. Dr. #430 Greenbelt, Md. 20770</b>				
31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>				32. Registrar's Signature <b>[Signature]</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04712

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CALVIN FLANNAGAN, SR.					2. Date of Death Month Day Year January 29, 1999		3. Time of Death 3:20 P.M.	
	4a. Facility Name (If not institution, give street and number) 6604 Greig St. # 102					4b. City, Town, or Location of Death Capitol Hgts.		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 235-22-2146		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11/5/23		9. Birthplace (State or Foreign Country) Braddock, Pa.
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md.	10b. County P.G.	10c. City, Town or Location Capitol Hgts.				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 6604 Greig St. # 102				10f. Zip Code 20743		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouseman		16b. Kind of Business/Industry Warehousing				
	17. Father's Name (First, Middle, Last) Samuel Flannagan					18. Mother's Name (First, Middle, Maiden Surname) Katie Miller			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Calvin Flannagan/Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5611 Partlow Rd., Partlow, Va. 22534			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory, Inc.		Date 2/3/99		20c. Location - City or Town, State Beltsville, Md.	
	21. Signature of Funeral Service Licensee <i>Larry W. B...</i>					22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 20019			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <i>Cardio-Respiratory arrest</i> Due to (or as a consequence of): b. <i>C.H.F.</i> Due to (or as a consequence of): c. <i>Diabetes mellitus</i> Due to (or as a consequence of): d. <i>Bilateral Amputation of legs</i>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <i>A O Moshedy</i>					29c. License number D09179		29d. Date signed (Month, Day, Year) February 1, 1999		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ata Moshedy, M.D. 7305 Hanover Pkwy. # A, Greenbelt, Md. 20770									
31. Date filed (Month, Day, Year) FEB 02 1999			32. Registrar's Signature <i>A. Moshedy</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04713

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John P. Forney

2. Date of Death

January 29 1999

3. Time of Death

1:25 PM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

577-32-6065

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 26 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Berwyn Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5803 Ruatan Street

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Automotive Parts Manager

16b. Kind of Business/Industry

Capitol Nissan

17. Father's Name (First, Middle, Last)

John R. Forney

18. Mother's Name (First, Middle, Maiden Surname)

Catherin G. Dixon

19a. Informant's Name/Relationship (Type, Print)

Mary L. Forney (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5803 Ruatan St. Berwyn Heights, MD 20740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Geo. Washington Cemtery

Date

2/2.99

20c. Location - City or Town, State

Adelphi, MD

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Rendon/Hale Funeral Home  
9013 Annapolis Rd. Lanham, MD 20706

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

b. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

c. RESPIRATORY FAILURE

Due to (or as a consequence of):

d. ASPIRATION PNEUMONIA

Approximate Interval Between Onset and Death

1 DAY

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

PERIPHERAL VASCULAR DISEASE

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D 20757

29d. Date signed (Month, Day, Year)

1/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Ko 8100 Goodluck Road Lanham Md. 20706

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

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6

JOHN FORNEY

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04714

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Evelyn Catherine Friend</b>						2. Date of Death Month Day Year <b>FEBRUARY 2, 1999</b>		3. Time of Death <b>0345 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>						4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>		
Funeral Director	5. Social Security Number <b>218-68-4748</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 16, 1909</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Friendsville</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number <b>140 Walnut Street</b>				10f. Zip Code <b>21531</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>				
17. Father's Name (First, Middle, Last) <b>Walter F. Humberson</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Umbel</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Leota P. Stover/Daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. Box 343, Friendsville, MD 21531</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Blooming Rose Cem., Feb. 5, 1999</b>		20c. Location - City or Town, State <b>Friendsville, MD</b>					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Newman Funeral Homes, P.A. 179 Miller St., PO Box 275, Grantsville, MD 21536</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute renal insufficiency</b> Due to (or as a consequence of): <b>b. Congestive Heart Failure</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>14 days</b> <b>2 years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b> <b>Malnutrition</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>D35135</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 2 1999</b>	
30. Name and address of person who completed cause of death (Verify 23a) (Type, Print) <b>Thomas E. Chappell, MD 912 Seton Dr. Cumberland MD 21502</b>											
31. Date filed (Month, Day, Year) <b>FEB 03 1999</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04715

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>NANNIE I. FLETCHER</b>				2. Date of Death Month Day Year <b>Jan 31, 1999</b>		3. Time of Death <b>2:35 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>DEVLIN MANOR NURSING HOME</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
<b>Funeral Director</b>	5. Social Security Number <b>218-62-7241</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec 25, 1908</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
10e. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1530 C Old Towne Manor</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>George A. Athey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl P. (Matthew)</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Stanley Robinette--nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>840 Michigan Avenue; Cumberland, MD 21502</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Davis Memorial Cemetery</b>		Date <b>02/02</b>		20c. Location - City or Town, State <b>Cumberland, MD</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Scarpelli Funeral Home, P.A. Cumberland, MD 21502</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CEREBROVASCULAR ACCIDENT</b> Due to (or as a consequence of):  Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of):  <b>c. _____</b> Due to (or as a consequence of):  <b>d. _____</b>								Approximate Interval Between Onset and Death <b>ONE DAY</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 			29c. License number <b>D14865</b>		29d. Date signed (Month, Day, Year) <b>Feb. 2, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Robustiano Barrera; Memorial Hospital Med. Bldg; Cumberland, MD 21502</b>								
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

MS

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 04716

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Elizabeth Fling				2. Date of Death Month: FEB Day: 3 Year: 1999		3. Time of Death 6:25 PM	
	4a. Facility Name (If not institution, give street and number) 510 Brunswick street				4b. City, Town, or Location of Death Brunswick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 213-16-1912		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) October 18 1919 Maryland	
	10e. State MD		10b. County Frederick		10c. City, Town or Location Brunswick		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 510 Brunswick Street				10f. Zip Code 21716		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) File Clerk		16b. Kind of Business/Industry Geico, Insurance	
	17. Father's Name (First, Middle, Last) Jerome J. Hoffman				18. Mother's Name (First, Middle, Maiden Surname) Virgil M. Welty			
	19a. Informant's Name/Relationship (Type, Print) Larry K. Paxson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Brunswick St., Brunswick, MD 21716			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Park Heights Cemetery 2/8 Brunswick, MD		20c. Location - City or Town, State		20d. Location - City or Town, State	
	21. Signature of Funeral Service Licensee Barbara A. Williams, Owner				22. Name and Address of Facility John I. Williams Funeral Home 100 Petersville Rd Brunswick MD 21716			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. METASTATIC BREAST CANCER							
	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier L. Ilgani MD		29c. License number D16675		29d. Date signed (Month, Day, Year) 2/4/99			
	30. Name and address of person who completed cause of death (Item 23e) (Type Print) WAYNE AUGER, BRUNSWICK, MD 21716							
	31. Date filed (Month, Day, Year) FEB 08 1999		32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04717

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leona Audra FEAGA				2. Date of Death February 4, 1999		3. Time of Death 7:11 PM	
	4a. Facility Name (If not institution, give street and number) 1510 West Eighth Street				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 218-24-9177		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 28, 1926	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1510 West Eighth Street		10f. Zip Code 21702		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager/Waitress		16b. Kind of Business/Industry Food Service			
	17. Father's Name (First, Middle, Last) Elmer Bussard, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mamie Murray			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Betty Y. Winpigler, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5321 Reels Mill Road, Frederick, Maryland 21704			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, February 8, 1999		20c. Location - City or Town, State Frederick, Maryland			
	21. Signature of Funeral Service Licensee Richard E. [Signature] MO0255		22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, MD 21701					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>metastatic non small cell lung cancer</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier [Signature] MD				29c. License number D 48184		29d. Date signed (Month, Day, Year) February 5, 1999	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Elhamy Eskander MD 501 West Seventh Street, Frederick, Maryland 21701							
	31. Date filed (Month, Day, Year) FEB 05 1999				32. Registrar's Signature [Signature]			





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04718

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna E. Gundecker

2. Date of Death

Month

Day

Year

February

02,

1999

3. Time of Death

1:30 PM

4a. Facility Name (If not institution, give street and number)

Calvert Manor Healthcare Center

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

061-09-0654

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 22, 1907

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1881 Telegraph Rd.

10f. Zip Code

21911

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Telephone Company

17. Father's Name (First, Middle, Last)

Jacob Gundecker

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Bastian

19a. Informant's Name/Relationship (Type, Print)

Lillian Vitelli/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

116 Ashley Place New Bern, NC 28562

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

2-6-99

20c. Location - City or Town, State

Maspeth, New York

21. Signature of Funeral Service Licensee

Richard L. Goodie

22. Name and Address of Facility

R. T. Foard Funeral Home, P. A.  
111 S. Queen St., Rising Sun, MD 21911

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ALZHEIMER'S DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 YEARS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Suresh Dhanjani MD

29c. License number

D45344

29d. Date signed (Month, Day, Year)

2-2-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESH DHANJANI, MD, 20 CRAIGTOWN RD, PERRYVILLE, MD 21903

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

P. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04719

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Andrea M. Gooding

2. Date of Death

Jan 29 1999

3. Time of Death

2155

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

213-38-3800

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 22, 1940

9. Birthplace (State or Foreign Country)

WASH. D.C.

Usual Residence of Decedent

10a. State

VA

10b. County

Westmoreland

10c. City, Town or Location

Colonial Beach

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

103 LONDON LANE

10f. Zip Code

22443

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)  
Elementary/Secondary (0-12) College (14 or 5+)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)  
Food Svc. - Delivery Worker

16b. Kind of Business/Industry

COUNTY SCHOOL SYSTEM

17. Father's Name (First, Middle, Last)

EDWARD L. Gooding

18. Mother's Name (First, Middle, Maiden Summa)

Ruth M Trochoweski

19a. Informant's Name/Relationship (Type, Print)

ANN M BASSO/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5010 ADRIAN ST ROCKVILLE MD 20853

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATORY

Date

2-1-99

20c. Location - City, Town, State

BELTSVILLE MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

STERLING FUNERAL SVC  
1601 KENILWORTH AVE NE WASH DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DMF

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Medical Examiner2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MDME

29c. License number

D 00426

29d. Date signed (Month, Day, Year)

Jan 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRA N BRECKER, MDME

2101 medical Park Dr Silver Spring MD 20901

31. Date filed (Month, Day, Year)

FEB 03 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

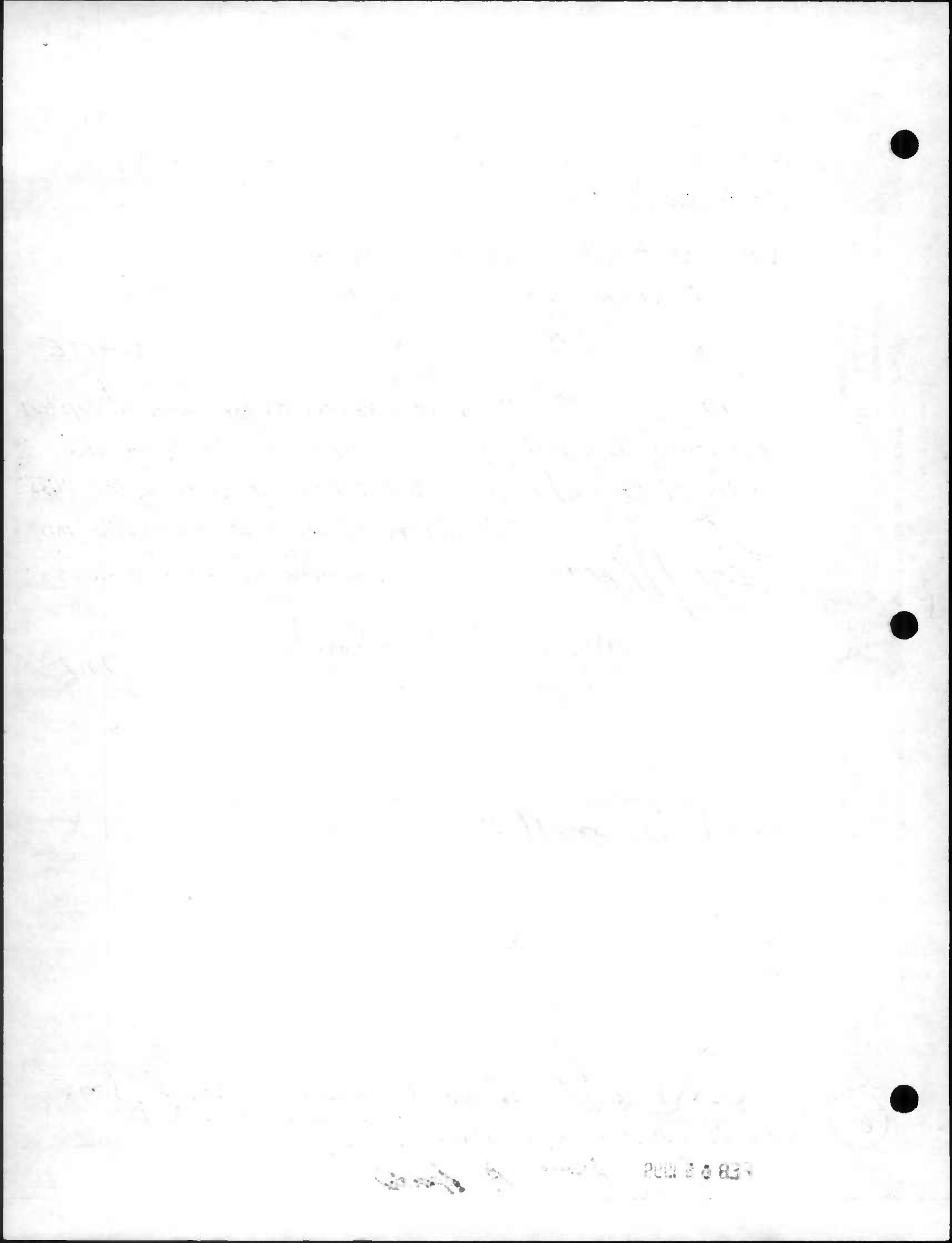
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04720

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GERALD GAINOUS</b>				2. Date of Death Month Day Year <b>JANUARY 29, 1999</b>		3. Time of Death <b>3:40 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Prince George's Hospital Center 3001 Hospital Dr</b>				4b. City, Town, or Location of Death <b>Cheverly, MD</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>579-48-8758</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>JAN. 8, 1935</b>		9. Birthplace (State or Foreign Country) <b>WASH., DC</b>	
	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State <b>MARYLAND</b>		10b. County <b>PRINCE GEORGE'S</b>		10c. City, Town or Location <b>LANDOVER</b>		10e. Street and Number <b>6201 OSBORN RD.</b>		
10f. Zip Code <b>20785</b>		10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>AF</b> If Yes, Give Year or Dates: <b>1952-1972</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>STRATEGIC AIR COMMAND (GUNNER)</b>		16b. Kind of Business/Industry <b>GOVT.- AIR FORCE</b>		
17. Father's Name (First, Middle, Last) <b>WAYMON M. GAINOUS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EULA M. SIMMONS</b>				
19a. Informant's Name/Relationship (Type, Print) <b>JACQUELINE G. HOWARD/ SISTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6201 OSBORN RD. LANDOVER, MD 20785</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND VETERANS CEM.</b>		Date <b>2-5-99</b>		20c. Location - City or Town, State <b>CHELTENHAM, MARYLAND</b>		
21. Signature of Funeral Service Licensee <b>Juanana L. Braxton</b>				22. Name and Address of Facility <b>MARSHALL'S FUNERAL HOME OF MD</b> <b>4308 SUITLAND RD. SUITLAND, MD 20746</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>PULMONARY EDEMA</b> Due to (or as a consequence of): b. <b>END STAGE RENAL DISEASE</b> Due to (or as a consequence of): c. <b>HYPERTENSION</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Anil K. Mahajan MD.</b>						
		29c. License number <b>MARYLAND MD 150689</b>		29d. Date signed (Month, Day, Year) <b>11/29/99.</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anil Mahajan 3001 Hospital Ad. Cheo. Md.</b>								
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

FEB 03 1982



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04721

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

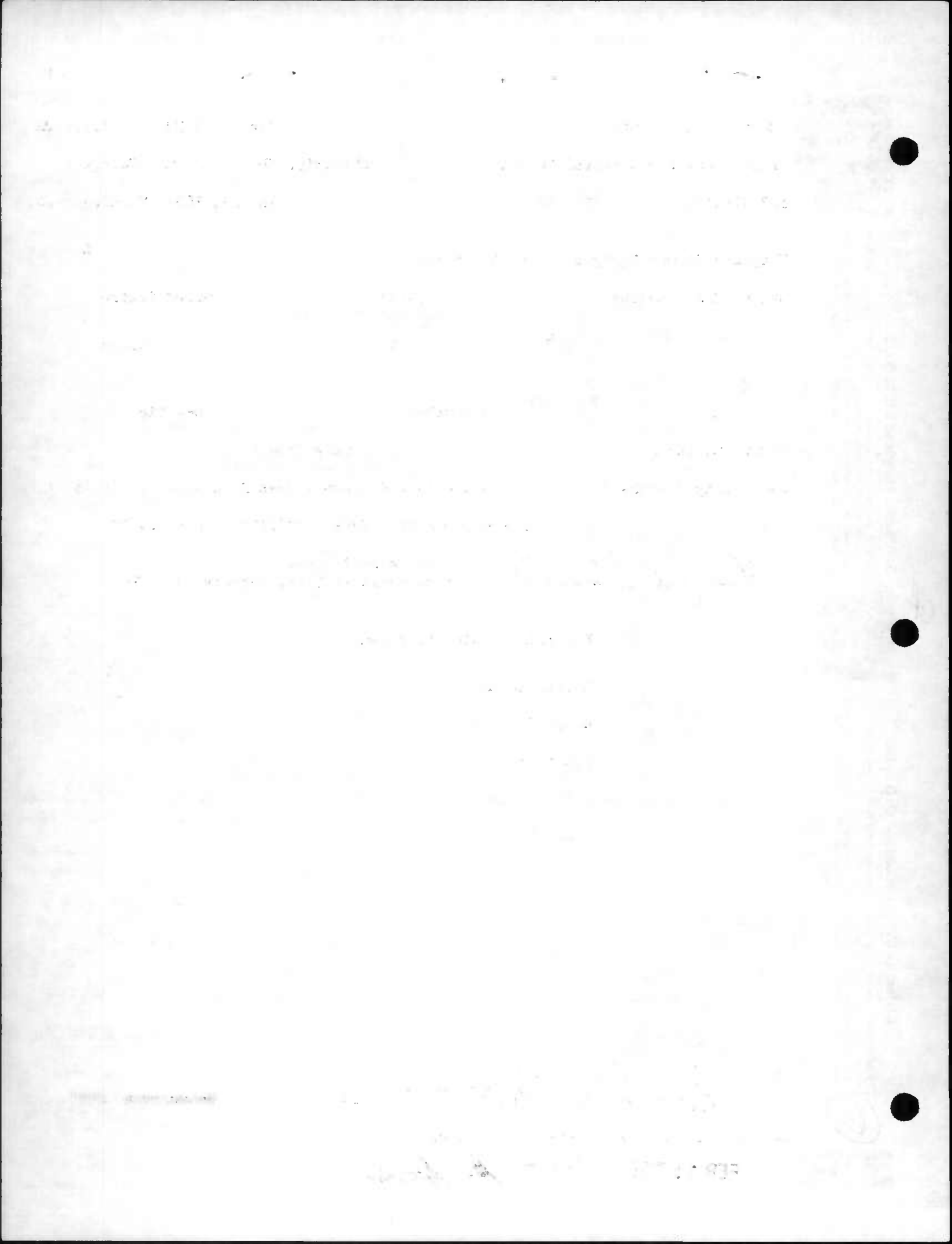
Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Teresa Maria Gray</b>				2. Date of Death Month Day Year <b>Jan 26, 1999</b>		3. Time of Death <b>11:30 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Prince George's Hospital Center</b>				4b. City, Town, or Location of Death <b>Cheverly, MD</b>		4c. County of Death <b>Prince George's</b>	
5. Social Security Number <b>577-70-5428</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan 22, 1951</b>	
9. Birthplace (State or Foreign Country) <b>Washington, DC</b>							
10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Seat Pleasant</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>504 Goldleaf Avenue</b>				10f. Zip Code <b>20743</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Domestic</b>	
17. Father's Name (First, Middle, Last) <b>Arthur C. Thomas</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Thomas</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Lewis Gray / Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>504 Goldleaf Avenue, Seat Pleasant, MD 20743</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harmony Memorial Park</b>		Date <b>2/1/99</b>		20c. Location - City or Town, State <b>Landover, MD</b>	
21. Signature of Funeral Service Licensee <i>Larry L. Simmons</i>				22. Name and Address of Facility <b>Pope Funeral Homes</b> <b>5538 Marlboro Pike, Forestville, MD</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Possible Cardiac Arrhythmia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Hyperkalemia</b> Due to (or as a consequence of): <b>Renal Failure</b> Due to (or as a consequence of): <b>Hypertension</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Erica Blair Muldrew</i>		29c. License number <b>D0052760</b>		29d. Date signed (Month, Day, Year) <b>February 4, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>3001 Hospital Drive, Cheverly, Maryland</b>							
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature <i>[Signature]</i>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04722

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) FLORENCE LILLIE GREEN				2. Date of Death Month Day Year FEBRUARY 7 1999				3. Time of Death 04:35 AM			
4a. Facility Name (If not institution, give street and number) ALLEGANY CO. NURSING HOME				4b. City, Town, or Location of Death CUMBERLAND				4c. County of Death ALLEGANY			
5. Social Security Number 214-07-6075		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN 26 1908		9. Birthplace (State or Foreign Country) MARYLAND			
Usual Residence of Decedent											10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND							
10e. Street and Number 433 HENDERSON AVE.				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSE KEEPER				16b. Kind of Business/Industry HOUSE KEEPER			
17. Father's Name (First, Middle, Last) HORACE JOSEPH GREEN						18. Mother's Name (First, Middle, Maiden Surname) MARY ALICE BARNARD					
19a. Informant's Name/Relationship (Type, Print) ROBERT C. ADAMS FRIEND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 DECATUR STREET CUMBERLAND MARYLAND 21502							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN CEMETERY FEBRUARY 10 1999		Date		20c. Location - City or Town, State LONACONING MARYLAND			
21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Advanced Alzheimer's Dementia</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.											Approximate Interval Between Onset and Death 12 yrs.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>D. L. Merritt</i>				29c. License number D-14865				29d. Date signed (Month, Day, Year) FEB. 7, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. J. BARRERA, MD CUMBERLAND, MD. 21502											
31. Date filed (Month, Day, Year) FEB 08 1999				32. Registrar's Signature <i>[Signature]</i>							

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amended#1 perPhyG768 2/22/99 EW

99 04723

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BENNETT RAYMOND GOAD</b> Raymond Bennett Goad		2. Date of Death Month Day Year <b>FEBRUARY 5, 1999</b>		3. Time of Death <b>0607</b>												
	4a. Facility Name (If not institution, give street and number) <b>SACRED HEART HOSP</b>		4b. City, Town, or Location of Death <b>CUMBERLAND ALLEGANY</b>		4c. County of Death												
Funeral Director	5. Social Security Number <b>220-30-8425</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.												
	8. Date of Birth (Month, Day, Year) <b>APRIL 2 1936</b>		9. Birthplace (State or Foreign Country) <b>PA.</b>														
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>ALLEGANY</b>	10c. City, Town or Location <b>CUMBERLAND</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No												
	10e. Street and Number <b>703 GEPHART DRIVE</b>		10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>U.S.A.</b>												
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>USAF</b>		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>U.S. POSTAL SERVICE</b>		16b. Kind of Business/Industry <b>MAIL MAN</b>												
	17. Father's Name (First, Middle, Last) <b>EARL BENNETT GOAD</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN MARY WAKEFOOSE</b>														
	19a. Informant's Name/Relationship (Type, Print) <b>ROSALIE DUNN SISTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12400 VALEN DRIVE CUMBERLAND MARYLAND 21502</b>														
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ROCKY GAP VET CEMETERY FEB 8 1999</b>		20c. Location - City or Town, State <b>FLINTSTONE RFD MD.</b>												
	21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>		22. Name and Address of Facility <b>MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND</b>														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td><b>PULMONARY HYPERTENSION</b></td> <td><b>5 YEARS</b></td> </tr> <tr> <td>b.</td> <td><b>PULMONARY EMBOLISM</b></td> <td><b>5 YEARS</b></td> </tr> <tr> <td>c.</td> <td><b>DEEP VENOUS THROMBOSIS</b></td> <td><b>5 YEARS</b></td> </tr> <tr> <td>d.</td> <td><b>AUTOMOBILE ACCIDENT</b></td> <td><b>5 YEARS</b></td> </tr> </table>					Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>PULMONARY HYPERTENSION</b>	<b>5 YEARS</b>	b.	<b>PULMONARY EMBOLISM</b>	<b>5 YEARS</b>	c.	<b>DEEP VENOUS THROMBOSIS</b>	<b>5 YEARS</b>	d.	<b>AUTOMOBILE ACCIDENT</b>
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>PULMONARY HYPERTENSION</b>	<b>5 YEARS</b>														
	b.	<b>PULMONARY EMBOLISM</b>	<b>5 YEARS</b>														
	c.	<b>DEEP VENOUS THROMBOSIS</b>	<b>5 YEARS</b>														
	d.	<b>AUTOMOBILE ACCIDENT</b>	<b>5 YEARS</b>														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEVERE COPD</b> <b>HYPOXEMIA</b>																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>James M. Raver</i>		29c. License number <b>D18764</b>													
29d. Date signed (Month, Day, Year) <b>FEBRUARY 8, 1999</b>		29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AMES M. RAVEN SUITE 400 MEMORIAL HOSP</b>															
31. Date filed (Month, Day, Year) <b>FEB 08 1999</b>		32. Registrar's Signature <i>James B. Raver</i>															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04724

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>EMMA JANE GIFFORD</b>				2. Date of Death Month Day Year <b>February 4, 1999</b>		3. Time of Death <b>1:30 A.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>1212 Random Ridge Road</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>	
5. Social Security Number <b>220-36-7962</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b>		8. Date of Birth (Month, Day, Year) <b>July 25, 1935</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Mt. Airy</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>7001 Watersville Road</b>				10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>+4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registered Nurse</b>		16b. Kind of Business/Industry <b>Medical</b>	
17. Father's Name (First, Middle, Last) <b>Oliver Basil Driver</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Beatrice Elizabeth Hall</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Wayne D. Gifford, son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1212 Random Ridge Road Westminster, MD 21157</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Poplar Springs</b>		Date <b>2/8/99</b>		20c. Location - City or Town, State <b>Mt. Airy, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Ranny P. Savage</i>				22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 8 East Ridgeville Blvd. Mt. Airy, MD 21771</b>			
23a. Part I: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Advanced uterine leiomyosarcoma</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>3 yrs</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and Title of certifier <i>[Signature]</i> MD				29c. License number <b>D0053702</b>		29d. Date signed (Month, Day, Year) <b>2-6-99</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Jesus G. Berdeja 600 N. Wolfe St Baltimore, MD 21287</b>							
31. Date filed (Month, Day, Year) <b>FEB 08 1999</b>				32. Registrar's Signature <i>[Signature]</i>			

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04725

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Thelma Baldwin Garrett</b>				2. Date of Death Month Day Year <b>February 1, 1999</b>		3. Time of Death <b>9:30 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Jones Acres Assisted Living Center</b>				4b. City, Town, or Location of Death <b>Arnold</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>425-07-3590</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 10, 1907</b>	
	9. Birthplace (State or Foreign Country) <b>Alabama</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severna Park</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>657 Shore Road</b>		10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>1</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bookkeeper</b>		16b. Kind of Business/Industry <b>Automobile Dealership</b>				
17. Father's Name (First, Middle, Last) <b>Louis Baldwin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edna May Lucier</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Elinor G. Adensam / daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>657 Shore Road, Severna Park, MD 21146</b>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>Feb 2 1999</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Heart Failure</b> Due to (or as a consequence of): <b>b. Carcinoma of the lung</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D16868</b>		29d. Date signed (Month, Day, Year) <b>February 2, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Oscar Farias, M.D., 1667 Crofton Center #1, Crofton, MD 21114</b>								
31. Date filed (Month, Day, Year) <b>FEB 03 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 410-588-6000.

Physician  
/Medical  
Examiner

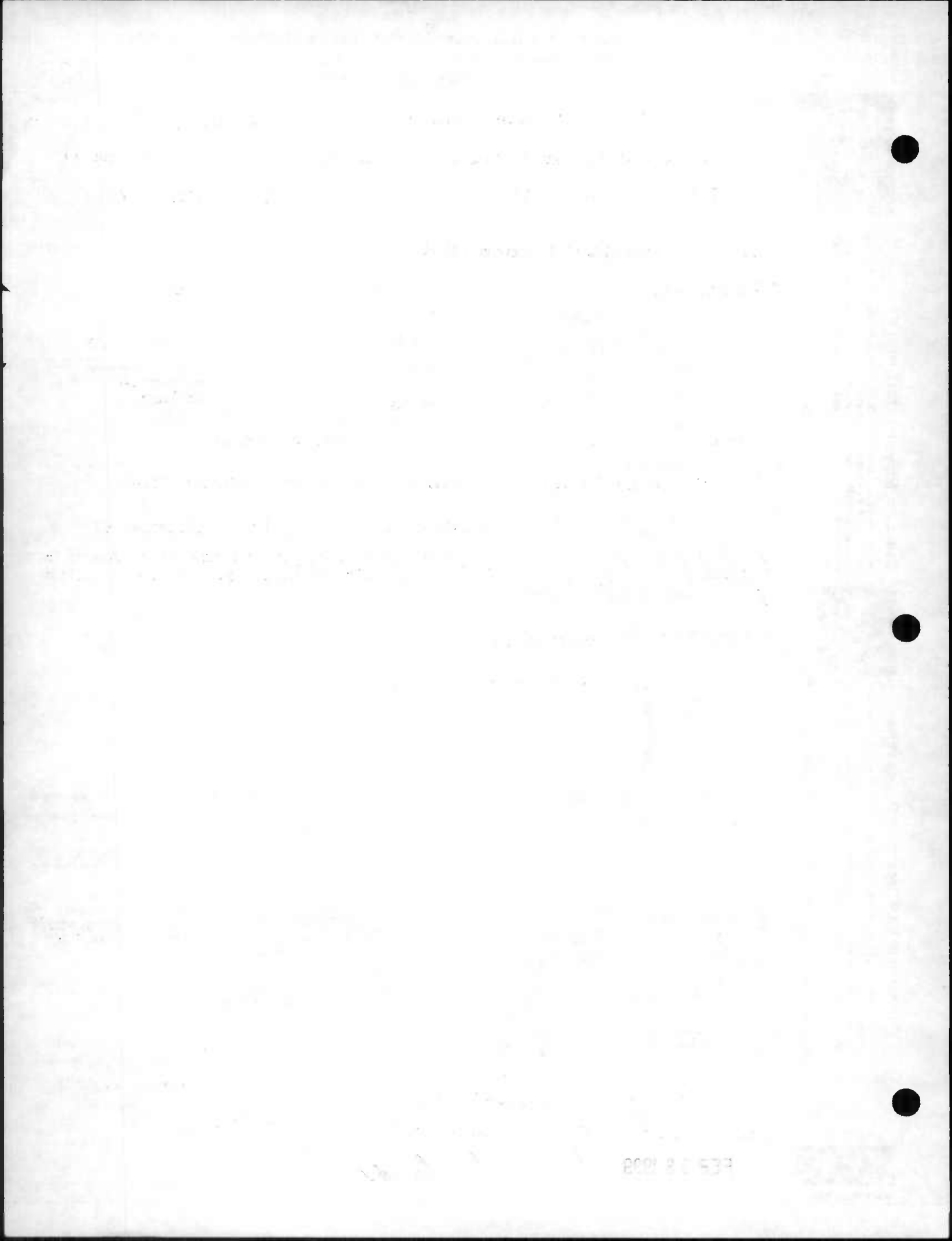
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04726

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUTH ALBERTA GREEN</b>				2. Date of Death Month Day Year <b>JAN. 29 1999</b>		3. Time of Death <b>2150</b>	
	4a. Facility Name (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>ANNAPOLIS</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>578-05-9530</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth Month Day Year <b>AUG. 25 1915</b>	
	9. Birthplace (State or Foreign Country) <b>D.C.</b>		10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>CROWNSVILLE</b>	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>1284 BACON RIDGE ROAD</b>		10f. Zip Code <b>21032</b>		10g. Citizen of What Country? <b>US</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MESSENGER</b>		16b. Kind of Business/Industry <b>FEDERAL GOVERNMENT</b>				
17. Father's Name (First, Middle, Last) <b>JOHN STEWART</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>FANNIE ROWE</b>				
19a. Informant's Name/Relationship (Type, Print) <b>FRANCES JACKSON (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1283 BACON RIDGE RD. CROWNSVILLE, MD. 21032</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HILL CREST CEMETERY</b>		Date <b>2/4/99</b>		20c. Location - City or Town, State <b>ANNAPOLIS, MD.</b>		
21. Signature of Funeral Service Licensee <b>Harry B. Reese</b>				22. Name and Address of Facility <b>WM. REESE &amp; SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <b>myocardial infarction</b>				Approximate Interval Between Onset and Death <b>hours</b>		
Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):						
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic obstructive pulmonary disease, history of pneumonia with respiratory failure, pseudoobstruction bowel, dementia</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D41955</b>		29d. Date signed (Month, Day, Year) <b>2-1-99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rebecca Eton MD 1454 B+A Blvd Arnold MD 21012</b>								
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04727

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE KENNETH HAYDEN

2. Date of Death

Month  
FEB.

Day  
6,

Year  
1999

3. Time of Death

7:30 PM

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LA PLATA, MD.

4c. County of Death

CHARLES

Funeral  
Director

5. Social Security Number

216-07-6261

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Month

Day

Year

March 19, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Bel Alton

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9055 Fairgrounds Road

10f. Zip Code

20611

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married

☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Field Engineer

16b. Kind of Business/Industry

Telephone Co.

17. Father's Name (First, Middle, Last)

Maurice D. Hayden

18. Mother's Name (First, Middle, Maiden Surname)

Mary C. Simpson Hayden

19a. Informant's Name/Relationship (Type, Print)

Doris Hayden/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 62 9055 Fairgrounds Rd. Bel Alton, MD 20611

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Ignatius Cemetery 2/09/99 Port Tobacco, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]* MOO174

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME P.A.

P.O. BOX 567 LA PLATA, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO PULMONARY ARREST

Approximate Interval Between Onset and Death

3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. BOWEL OBSTRUCTION & METASTATIC CARCINOMA

c. (PRIMARY UNKNOWN)

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE, ON PERITONEAL

DIALYSIS, WITH POSSIBLE CULTURE-

RELATIVE PERITONITIS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

MD0053431

Expires 09/30/2000

29d. Date signed (Month, Day, Year)

02/07/1999, 8:35 AM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAMMED S. KHALID, MD. 7C POST OFFICE ROAD WALDORF, MD. 20602

31. Date filed (Month, Day, Year)

FEB 08 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

George K. Hayden  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04728

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALEXANDER HURVITZ

2. Date of Death

Month Day Year  
FEBRUARY 4 1999

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

Hebrew Home Of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-05-8513A

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 27, 1907

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1801 East Jefferson Street, Apt. 519

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Cab Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Meyer Hurvitz

18. Mother's Name (First, Middle, Maiden Surname)

Yetta Gottlieb

19a. Informant's Name/Relationship (Type, Print)

Edith Ritzenberg, Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2301 Glen Allan Avenue  
Silver Spring, Maryland 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beth Shalom Congregation  
Cemetery

Date

February 5, 1999

20c. Location - City or Town, State

Capitol Heights, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

STEIN HEBREW MEMORIAL FUNERAL HOME, INC.

232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. VIRAL SYNDROME  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. Talwar

29c. License number

D 36552

29d. Date signed (Month, Day, Year)

FEBRUARY 4 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

P. TALWAR, 6121 MONTROSE ROAD ROCKVILLE MD 20852

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

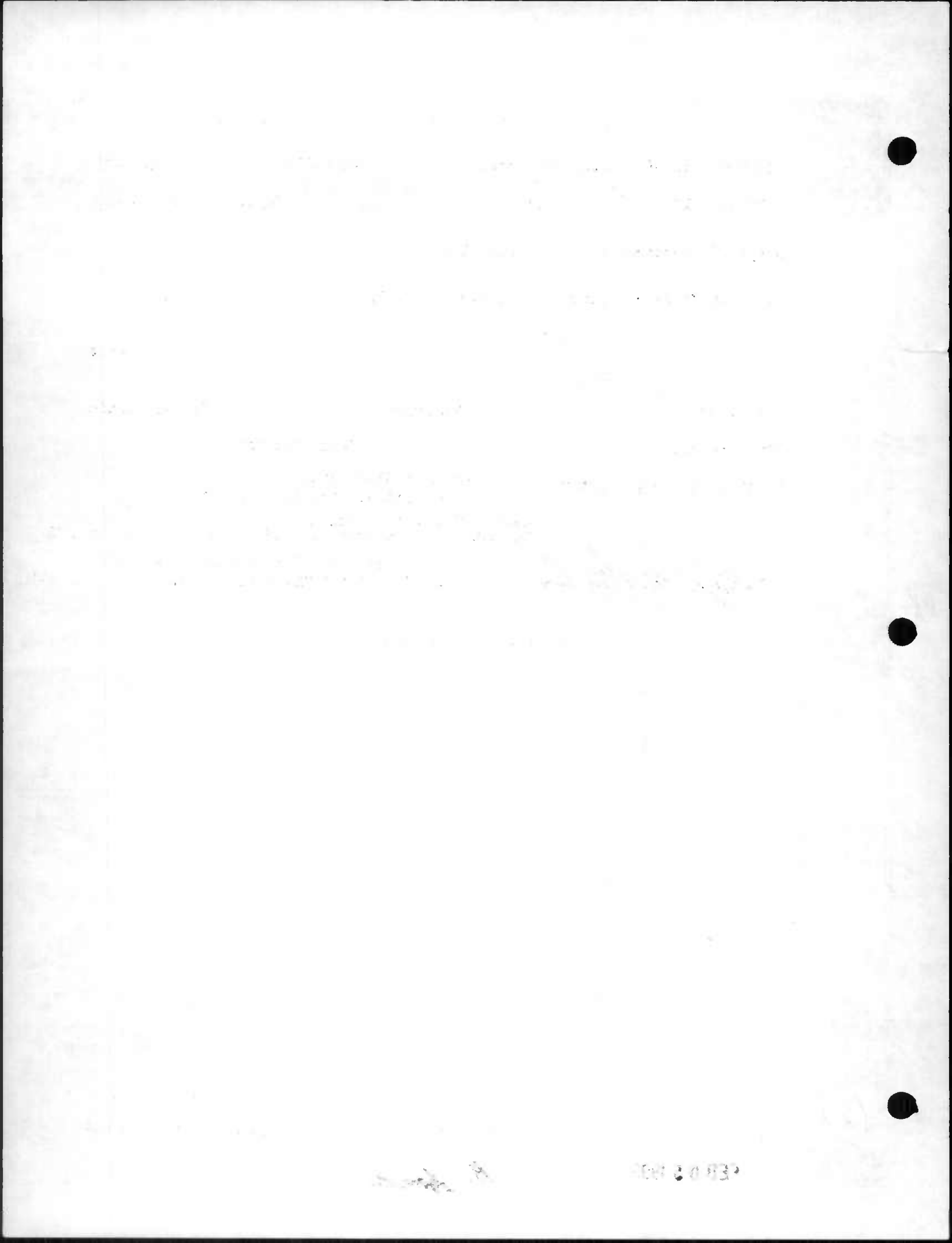
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04729

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT F. HOYLE				2. Date of Death Month Day Year January 31, 1999		3. Time of Death 10:10 PM	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 579-62-1019		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) March 23, 1948	
							9. Birthplace (State or Foreign Country) Washington DC	
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State D.C.		10b. County N/A		10c. City, Town or Location Washington		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 1673 Columbia Road N.W., #311				10f. Zip Code 20009		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 4 +		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry D.C. Public School Sys.			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Oscar C. Hoyle				18. Mother's Name (First, Middle, Maiden Surname) Helen Darby			
	19a. Informant's Name/Relationship (Type, Print) Helen G. Lynch - Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1889 Ingleside Terrace N.W. Washington, DC 20010			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Data 2/6/99		20c. Location - City or Town, State Brentwood, MD	
	21. Signature of Funeral Service Licensee J. P. Marshall				22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington DC 20011			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. decubitus ulcers Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 wk.			
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. End stage Renal dz Advanced AIDS						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number D46478		29d. Date signed (Month, Day, Year) 2-1-99		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Suresh A. Patel 7501 Surratt Rd. Clinton MD 20735								
State Registrar	31. Date filed (Month, Day, Year) FEB 05 1999		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

FEB 02 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04730

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID CAESAR HARRIS				2. Date of Death Month Day Year JANUARY 25, 1999		3. Time of Death 8:45pm			
	4a. Facility Name (If not institution, give street and number) MANOR CARE NURSING HOME				4b. City, Town, or Location of Death WHEATON		4c. County of Death MONTGOMERY			
Funeral Director	5. Social Security Number 158-70-9539		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) 11-24-15		9. Birthplace (State or Foreign Country) LIBERIA	
	Usual Residence of Decedent									
10a. State MD			10b. County MONTGOMERY			10c. City, Town or Location SILVER SPRING			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 11235 OAK LEAF DR. #715					10f. Zip Code 20901		10g. Citizen of What Country? LIBERIA			
11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5t				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MINISTER OF JUSTICE			16b. Kind of Business/Industry GOVT. OF LIBERIA			
17. Father's Name (First, Middle, Last) JEREMIAH J.J. HARRIS						18. Mother's Name (First, Middle, Maiden Surname) MARDIA WEEGBUAH				
19a. Informant's Name/Relationship (Type, Print) VICTORIA HARRIS / SPOUSE					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11235 OAK LEAF DR. #715 SILVER SPRING, MD 20901					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN		Date 2-6-99		20c. Location - City or Town, State SILVER SPRING, MD			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOME 11315 LOCKWOOD DRIVE, SILVER SPRING, MD 20904					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ARRYTHMIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									Approximate Interval Between Onset and Death MINUTES	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number D42518		29d. Date signed (Month, Day, Year) February 4, 1999			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GUL CHABLANI, M.D. 11119 ROCKVILLE, MD 20852										
31. Date filed (Month, Day, Year) FEB 05 1999			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

FEB 02 1968



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04731

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEVI HAWKINS</b>				2. Date of Death Month Day Year <b>January 28 1999</b>		3. Time of Death <b>11:35 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>10806 Joyceton Drive</b>				4b. City, Town, or Location of Death <b>Upper Marlboro</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>579-32-2744</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 17, 1926</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Upper Marlboro</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>10806 Joyceton Drive</b>		10f. Zip Code <b>20774</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>05/45 to 12/46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Government</b>			
	17. Father's Name (First, Middle, Last) <b>Levi George Hawkins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Frances C. Gray</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Leona J. Hawkins/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10806 Joyceton Drive, Upper Marlboro, MD 20774</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Ceme.</b>		20c. Location - City or Town, State <b>Cheltenham, Maryland</b>		20d. Date <b>02/05 1999</b>	
	21. Signature of Funeral Service Licensee <b>Nancy A. Perentie</b>				22. Name and Address of Facility <b>J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Adenocarcinoma of the Prostate, hormone-refractory, metastatic to bone</b> Due to (or as a consequence of):  b. <b>3 years</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>242979</b>		29d. Date signed (Month, Day, Year) <b>1/29/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael Carducci, M.D. 600 North Wolfe Street Baltimore, Maryland 21287</b>								
31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>				32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature", or item 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04732

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

LYRIS MADONACI HAREWOOD

2. Date of Death

January 29 1999

Day  
Yea

3. Time of Death

9:25 PM

4a. Facility Name (If not institution, give street and number)

Larkin Chase Nursing Home

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

5. Social Security Number

088-40-3646

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 26, 1907

9. Birthplace (State or Foreign Country)

Barbados, W.I.

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Landover Hills

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7011 Barton Road

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Rufus Lorde

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Bushell

19a. Informant's Name/Relationship (Type, Print)

Yvonne A. Stewart/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7011 Barton Road, Landover Hills, Maryland 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

02/05 1999

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive cardiovascular disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

man in breast

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. G. Bhojraj M.D.

29c. License number

D 23181

29d. Date signed (Month, Day, Year)

213199

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. G. BHOJRAJ M.D. 704 Gorman Ave # T-1, Laurel, MD 20707

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

R. G. Bhojraj M.D.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState  
Registrar

*Smith*

SEP 6 1961

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04733

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Luis Alonso Vega Hernandez

2. Date of Death

Month

Day

Year

Jan 30

1999

3. Time of Death

0830

4a. Facility Name (If not Institution, give street and number)

7515 Maple Ave

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-13-8269

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

January 28, 1954

9. Birthplace (State or Foreign Country)

El Salvador

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

7515 Maple Avenue

10f. Zip Code

20912

10g. Citizen of What Country?

El Salvador

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: El Salvadorian

14. Race - American Indian, Black, White, etc.

Specify: Hispanic

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Landover Mechanical Contractors

17. Father's Name (First, Middle, Last)

Luis Vega

18. Mother's Name (First, Middle, Maiden Surname)

Pastora Hernandez

19a. Informant's Name/Relationship (Type, Print)

Rosa E. Cruz Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7515 Maple Avenue Takoma Park, Md. 20912

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Family Cemetery

Date

02/06/99

20c. Location - City or Town, State

San Miguel, El Salvador

21. Signature of Funeral Service Licensee

Wanda C. Bacon #889

22. Name and Address of Facility

W.H. Bacon Funeral Home  
3447 14th Street N.W. Washington, D.C. 20010

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

b. Hypertensive cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DMF

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wanda C. Bacon

29c. License number

D00428

29d. Date signed (Month, Day, Year)

Jan 30, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

IRA N BRECHER, MD DME Silver Spring MD 20902

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 04734

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Albert Hardy Sr.				2. Date of Death Month Day Year Feb 1 1999		3. Time of Death 10:36pm	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-05-4062	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 3, 1915		9. Birthplace (State or Foreign Country) Wash., D.C.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State District of Columbia		10b. County Washington		10c. City, Town or Location Washington		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 1821 Burke St., S.E.				10f. Zip Code 20003		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Negro	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Government			
	17. Father's Name (First, Middle, Last) Henry Hardy				18. Mother's Name (First, Middle, Maiden Surname) Unknown			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sheila Coleman - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1821 Burke St., S.E. Wash., D.C. 20003			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Date 2/8/99		20d. Location - City or Town, State Landover, MD	
	21. Signature of Funeral Service Licensee John T. Stewart III				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. Cholangitis with septicemia Due to (or as a consequence of): b. Pancreatic Tumors Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Days  Months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Roy Fried MD				29c. License number D34590		29d. Date signed (Month, Day, Year) Feb 2 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy Fried MD 1500 Forest Glen Rd Silver Spring Md 20910								
State Registrar		31. Date filed (Month, Day, Year) FEB 05 1999		32. Registrar's Signature				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-524-2024.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

1987 01 08



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 04735

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Russell S. Henderson</b>				2. Date of Death Month Day Year <b>02/09/99</b>				3. Time of Death <b>0500 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>5028 River Road</b>				4b. City, Town, or Location of Death <b>Bethesda</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>519 16 1036</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>04/17/23</b>		9. Birthplace (State or Foreign Country) <b>Nevada</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>				10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
	10e. Street and Number <b>5028 River Road</b>				10f. Zip Code <b>20816</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>1941 to 1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Civil Engineer</b>				16b. Kind of Business/Industry <b>Federal Government</b>			
	17. Father's Name (First, Middle, Last) <b>Russell S. Henderson, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Vida Boley</b>					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Robert Henderson (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5028 River Road/Bethesda Md 20816</b>					
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>2/10/99</b>		20c. Location - City or Town, State <b>Alexandria VA</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Advent Funeral &amp; Cremation Services 7211 Lee Highway, Falls Church VA 22046</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Chronic Obstructive Lung Disease</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown  24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No  24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No						26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)			
	27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number <b>D33554</b>		29d. Date signed (Month, Day, Year) <b>02/10/99</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John E. Verg, II M.D. 5401 Western Ave NW, Washington D.C. 20015</b>									
	31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

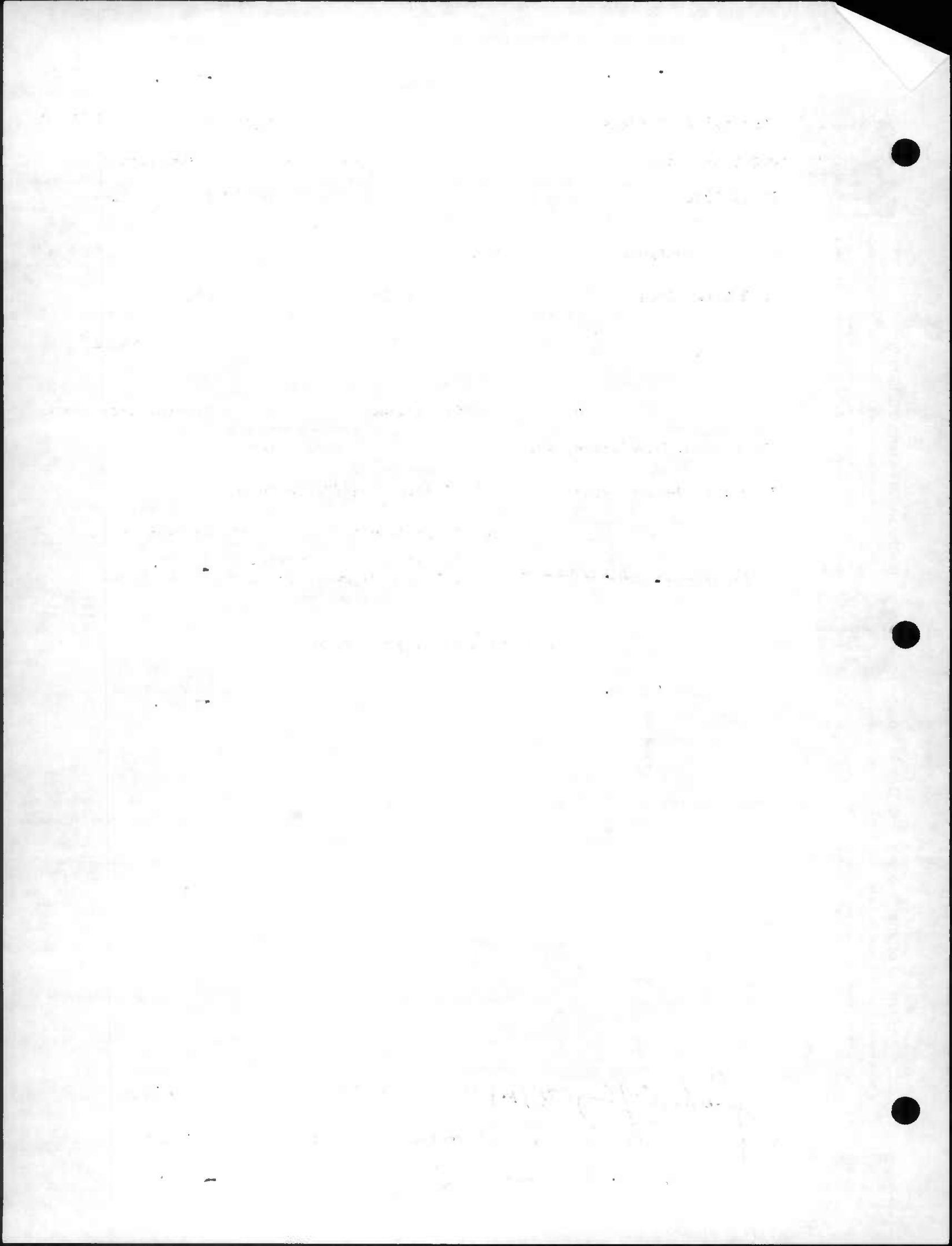
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04736

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Carl Hill</i>				2. Date of Death Month Day Year <i>February 3, 1999</i>		3. Time of Death <i>0758</i>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <i>230-50-4142</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <i>80</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Aug 18, 1918</i>	9. Birthplace (State or Foreign Country) <i>Virginia</i>
	Usual Residence of Decedent				10c. City, Town or Location <i>Chincoteague</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. State <i>Virginia</i>		10b. County <i>Accomack</i>		10f. Zip Code <i>23336</i>		10g. Citizen of What Country? <i>U. S. A.</i>	
	10e. Street and Number <i>6460 Holly Drive</i>		10f. Zip Code <i>23336</i>		10g. Citizen of What Country? <i>U. S. A.</i>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WW II</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>7</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Part Department</i>		16b. Kind of Business/Industry <i>Lockheed-Martin</i>			
	17. Father's Name (First, Middle, Last) <i>John W. Hill, Sr.</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Betty Jones</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Clara Hill Wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6460 Holly Drive, Chincoteague, Virginia 23336</i>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Douning Cemetery</i>		Date <i>2-7-99</i>		20c. Location - City or Town, State <i>Oak Hall, Virginia</i>	
	21. Signature of Funeral Service Licensee <i>Signature of Clara Hill</i>				22. Name and Address of Facility <i>Salter Funeral Home Chincoteague, Virginia 23336</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>ISCHEMIC CARDIOMYOPATHY</i> Due to (or as a consequence of): b. <i>CORONARY ATHEROSCLEROSIS</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>DR. J. H. NASH, M.D.</i>		29c. License number <i>242075</i>		29d. Date signed (Month, Day, Year) <i>FEBRUARY, 3, 1999</i>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>PENINSULA CARDIOLOGY, 400 EASTERN SHORE DRIVE - SALISBURY</i>							
State Registrar	31. Date filed (Month, Day, Year) <i>FEB 05 1999</i>		32. Registrar's Signature <i>Benita B Sparks</i>					

Card Hill SS# 230-50-4142  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

The following is a list of the names of the persons who have been  
 named in the various reports of the Committee on the subject of  
 the proposed amendment to the Constitution of the State of New York.  
 The names are given in alphabetical order, and are taken from the  
 reports of the Committee, as published in the year 1894.  
 The names are given in the order in which they appear in the  
 reports of the Committee, and are not necessarily in the order  
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 in which they were named by the Committee.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04737

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARIE HOLLINS</b>				2. Date of Death Month <b>FEBRUARY</b> Day <b>1</b> Year <b>1999</b>		3. Time of Death <b>1042</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>231-74-8507</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT. 5, 1930</b>	9. Birthplace (State or Foreign Country) <b>RADFORD, VIRGINIA</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>WICOMICO</b>		10c. City, Town or Location <b>SALISBURY</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>213 CENTER STREET</b>				10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>SHERMAN HOLLINS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET LOVERN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>SUSAN S. HORVATH/NIECE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT. 1 BOX 340, SELBYVILLE, DELAWARE 19975</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HIGHLAND MEMORY GARDENS</b>		Date <b>2/8/99</b>		20c. Location - City or Town, State <b>DUBLIN, VIRGINIA</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of): <b>a. hypoxia</b> <b>b. lung mass</b> <b>c. respiratory failure.</b> <b>d. COPD</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D31546</b>		29d. Date signed (Month, Day, Year) <b>2/1/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. L. S. Nardo M.D. 106 MILFORD ST., Suite 3, SALISBURY, MD 21804</b>								
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04738

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>MARGARET C. HUMBERTSON</b>					2. Date of Death Month Day Year <b>FEBRUARY 5, 1999</b>			3. Time of Death <b>1:28 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>					4b. City, Town, or Location of Death <b>CUMBERLAND</b>			4c. County of Death <b>ALLEGANY</b>	
<b>Funeral Director</b>	5. Social Security Number <b>213-40-4075</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>55</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 19, 1943</b>		9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Little Orleans</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>34008 Harry Norris Road</b>				10f. Zip Code <b>21766</b>			10g. Citizen of What Country? <b>USA</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>			
17. Father's Name (First, Middle, Last) <b>Edward Clark</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Marjorie (Evans)</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Marjorie Morgan--daughter</b> <b>Sandy Hersh--daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>34008 Harry Norris Road; Little Orleans, MD 21766</b> <b>12024 Iris Avenue; Cumberland, MD 21502</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fairview Cemetery</b>			20c. Location - City or Town, State <b>02/08 Artemas, PA</b>				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Scarpelli Funeral Home, P.A.</b> <b>Cumberland, MD 21502</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>PULMONARAY EMBOLISM</b> Due to (or as a consequence of):										<b>15 MIN.</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>COR PULMONALE</b> Due to (or as a consequence of):										<b>3 MONTHS</b>
<b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b> Due to (or as a consequence of):										<b>5 YEARS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier  M.D.			29c. License number <b>23334 - 2</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 5th, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DINESH B. SHAH, M.D. 205 JOHNSON HEIGHTS MED BLDG., CUMBERLAND 21502, MD.</b>										
31. Date filed (Month, Day, Year) <b>FEB 09 1999</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



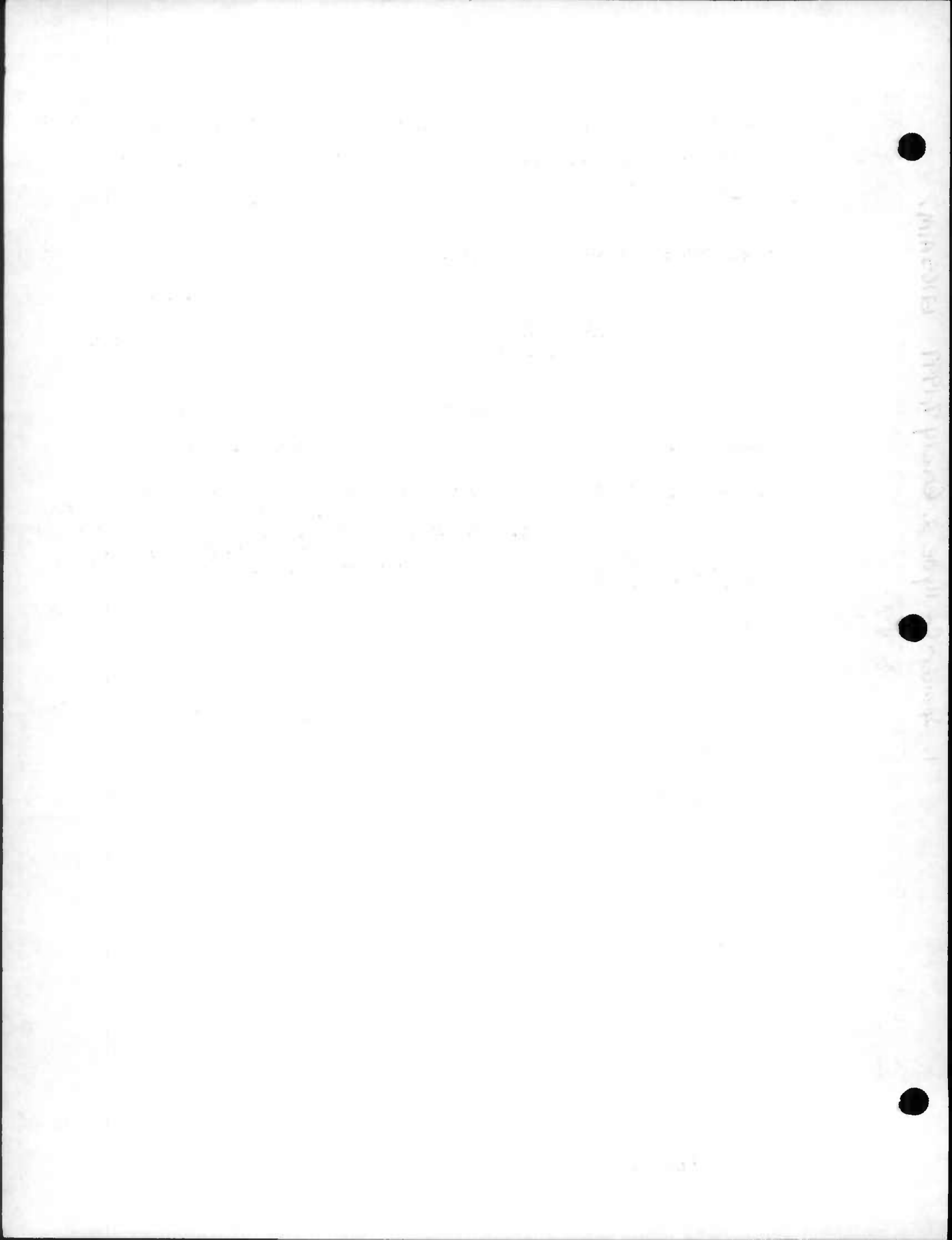


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 04739**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Spencer Clinton Hyde</b>			2. Date of Death Month <b>February</b> Day <b>7</b> Year <b>1999</b>			3. Time of Death <b>12:05AM</b>				
	4e. Facility Name (If not institution, give street and number) <b>Charlotte Hall Veterans Home</b>			4b. City, Town, or Location of Death <b>Charlotte Hall</b>			4c. County of Death <b>St. Mary's</b>				
Funeral Director	5. Social Security Number <b>578-22-2406</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 10, 1911</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Prince George's</b> 10c. City, Town or Location <b>Clinton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Funeral Director	10e. Street and Number <b>7323 Sheila Lane</b>			10f. Zip Code <b>20735</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1942-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>11th</b>			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Welder</b>			16b. Kind of Business/Industry <b>PEPCO</b>				
	17. Father's Name (First, Middle, Last) <b>Norval P. Hyde</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Rhoda I. Canter</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Constance M. Hyde (Wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7323 Sheila Lane Clinton, Maryland 20735</b>							
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Feb. 11, 1999</b> <b>St. Barnabas Episcopal Ch. Cem</b>			20c. Location - City or Town, State <b>Temple Hills Maryland</b>				
	21. Signature of Funeral Service Licensed			22. Name and Address of Facility <b>Lee Funeral Home, Inc.</b> <b>6633 Old Alexandria Ferry Rd Clinton, MD20735</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last			e. <b>Hypertensive heart disease</b> Due to (or as a consequence of): b. <b>Chronic obstructive Pulmonary disease</b> Due to (or as a consequence of): c. <b>Carcinoma of Prostate with</b> Due to (or as a consequence of): d. <b>Metastasis</b>			Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial Fibrillation</b>			23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <b>Thomas V. Joseph</b>			29c. License number <b>D 47330</b>			29d. Date signed (Month, Day, Year) <b>2/8/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Thomas Joseph - 7 Post office Rd. Waldorf, MD 20603</b>			31. Date filed (Month, Day, Year) <b>FEB 09 1999</b>			32. Registrar's Signature <b>B. Sparks</b>					




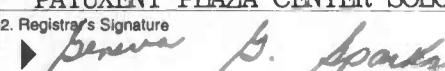
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04740

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRENE WASILKO HAUSSMANN</b>				2. Date of Death Month <b>FEBRUARY</b> Day <b>5</b> Year <b>1999</b>		3. Time of Death <b>10:45PM</b>					
	4a. Facility Name (If not institution, give street and number) <b>THE HERMITAGE AT ST. JOHN'S CREEK</b>				4b. City, Town, or Location of Death <b>SOLOMONS</b>		4c. County of Death <b>CALVERT</b>					
Funeral Director	5. Social Security Number <b>184-12-1211</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MARCH 21, 1925</b>					
	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>		10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>DEALE</b>					
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	10e. Street and Number <b>902 MAIN STREET</b>				10f. Zip Code <b>20751</b>		10g. Citizen of What Country? <b>U. S. A.</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>INS INVESTIGATOR</b>		16b. Kind of Business/Industry <b>DEPARTMENT OF JUSTICE</b>							
	17. Father's Name (First, Middle, Last) <b>ANDREW WASILKO</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>ANNA LUPCHO</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>KEVIN HAUSSMANN / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1625 CANNERY ROAD OWINGS, MARYLAND 20736</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FORT LINCOLN CEMETERY</b>		20c. Location - City or Town, State <b>BRENTWOOD, MARYLAND</b>							
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MD BLVD. OWINGS, MARYLAND 20736</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Congestive Heart Failure</b> Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>Aortic Stenosis</b> Due to (or as a consequence of):</td> </tr> <tr> <td>c. <b>Hepatic Encephalopathy</b> Due to (or as a consequence of):</td> </tr> <tr> <td>d. <b>Diabetes Mellitus</b> Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Congestive Heart Failure</b> Due to (or as a consequence of):	b. <b>Aortic Stenosis</b> Due to (or as a consequence of):	c. <b>Hepatic Encephalopathy</b> Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Congestive Heart Failure</b> Due to (or as a consequence of):											
	b. <b>Aortic Stenosis</b> Due to (or as a consequence of):											
	c. <b>Hepatic Encephalopathy</b> Due to (or as a consequence of):											
	d. <b>Diabetes Mellitus</b> Due to (or as a consequence of):											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. Signature and title of certifier  <b>David J. Tardio MD</b>				29c. License number <b>047610</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 8, 1999</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID J. TARDIO, M.D. PATUXENT PLAZA CENTER SOLOMONS, MARYLAND 20688</b>												
31. Date filed (Month, Day, Year) <b>FEB 09 1999</b>		32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

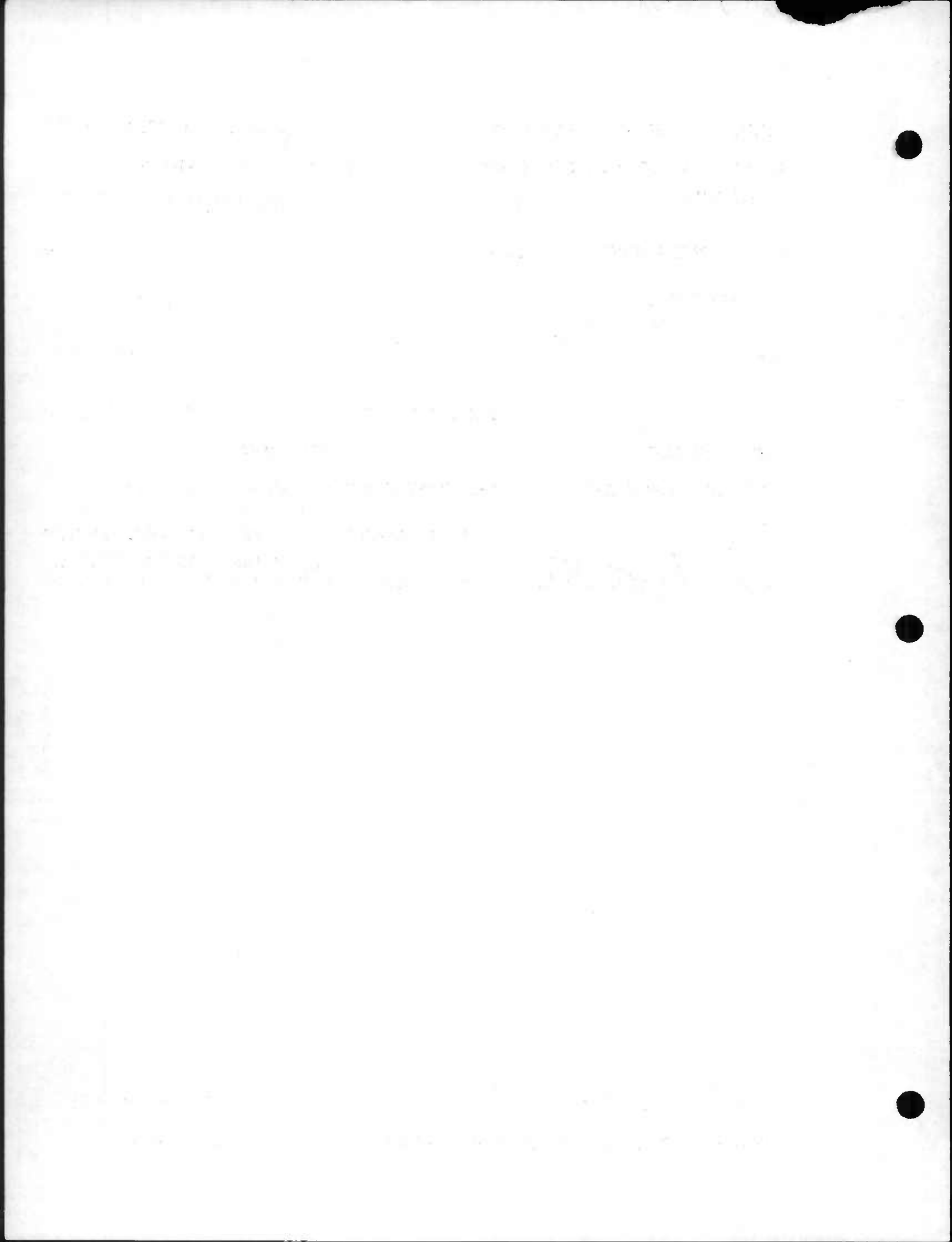
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04741

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ralph John Hellenschmidt</b>		2. Date of Death Month Day Year <b>FEBRUARY 03 1999</b>		3. Time of Death <b>1:22 A.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>MALCOLM GROW MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>CAMP SPRINGS</b>		4c. County of Death <b>PRINCE GEORGE'S</b>
Funeral Director	5. Social Security Number <b>061-20-7272</b>	6. Sex <b>2</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Nov. 20 1928</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Prince George's</b>	10c. City, Town or Location <b>Suitland</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>2312 Ewing Avenue #9</b>		10f. Zip Code <b>20746</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1946-</b> If Yes, Give Year or Dates: <b>1966</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Naval Photographer</b>		16b. Kind of Business/Industry <b>Federal Government</b>
	17. Father's Name (First, Middle, Last) <b>Kilian Hellenschmidt</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Margaruite Redding</b>		
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mary Hellenschmidt (Wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2312 Ewing Avenue #9 Suitland, Maryland 20746</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b>		20c. Location - City or Town, State <b>Arlington, Virginia</b>
	21. Signature of Funeral Service Licensee <b>St. F. Sitt</b>		22. Name and Address of Facility <b>Lee Funeral Home, Inc., 6633 Old Alexandria Ferry Road Clinton, MD 20735</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>ACUTE RESPIRATORY FAILURE</b> Dua to (or as a consequence of):  b. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Dua to (or as a consequence of):  c. Dua to (or as a consequence of):  d. Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BILATERAL TENSION PNEUMOTHORAX</b>					
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
State Registrar	29b. Signature and title of certifier <b>Stph. F.W. Cavanaugh</b>		29c. License number <b>KY 23372</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 03 1999</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STEPHEN F.W. CAVANAH, LTC, USAF, MC</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANDREWS AIR FORCE BASE, MD 20762-6600</b>		
	31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature <b>B. Sparks</b>		





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04742

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY CHARLES HOSSLER</b>				2. Date of Death Month Day Year <b>FEBRUARY 1, 1999</b>		3. Time of Death <b>8:15 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>217-18-7586</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 2, 1922</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>552 East Church Street</b>		10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Plumber</b>		16b. Kind of Business/Industry <b>Plumbing Contractor</b>					
17. Father's Name (First, Middle, Last) <b>Charles Hossler</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie Virginia Eyer</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Louise Hossler, wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>552 East Church Street, Frederick, MD 21701</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory, Feb. 2, 1999</b>		20c. Location - City or Town, State <b>Smithsburg, MD</b>					
21. Signature of Funeral Service Licensee <b>Richard E. May</b> MOO255		22. Name and Address of Facility <b>Keeney and Basford P.A. Funeral Home</b> <b>106 East Church St., Frederick, MD 21701</b>							
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): b. <b>RENAL INSUFFICIENCY</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death <b>YEARS</b> <b>YEARS</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Sherman Kahan MD</b>		29c. License number <b>D 12697</b>		29d. Date signed (Month, Day, Year) <b>FEB 1 1999</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>S KAHAN 915 TOLL HOUSE AVE #307 FREDERICK MD 21701</b>									
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature <b>B. Sparks</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04743

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Quentin HISER</b>				2. Date of Death Month <b>February</b> Day <b>1</b> Year <b>1999</b>		3. Time of Death <b>11:30 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>College View Center</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>233-34-5597</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 18, 1920</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>5690 Farmhouse Drive</b>				10f. Zip Code <b>21703</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1943-</b> If Yes, Give Year or Dates: <b>1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Graphic Artist</b>		16b. Kind of Business/Industry <b>Federal Government</b>			
	17. Father's Name (First, Middle, Last) <b>Bert Franklin HISER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Minnie Jane STUMP</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Helen I. Hiser/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5690 Farmhouse Drive, Frederick, Maryland 21703</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory Feb 5, 1999</b>		20c. Location - City or Town, State <b>Smithsburg, Maryland</b>			
	21. Signature of Funeral Service Licensed <b>Keelynn Roberson</b> MO0706		22. Name and Address of Facility <b>Keeney &amp; Basford P.A. Funeral Home</b> <b>106 East Church St, Frederick, Maryland 21701</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>pneumonia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Diabetes mellitus</b> <b>peripheral Vascular Disease</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>Casper E. Cline III</b>				29c. License number <b>D16428</b>		29d. Date signed (Month, Day, Year) <b>February 2, 1999</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Casper E. Cline III, M.D., 300 West Ninth Street, Frederick, Maryland 21701</b>							
	31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>				32. Registrar's Signature <b>B. Sparks</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04744

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph B. Hardesty				2. Date of Death Month Day Year February 3, 1999				3. Time of Death 12:45 AM	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare Center-Spa Creek				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 218-10-3464		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 93		8. Date of Birth (Month, Day, Year) May 19, 1905		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Edgewater				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 3043 Solomons Island Road				10f. Zip Code 21037		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer			16b. Kind of Business/Industry Agriculture		
	17. Father's Name (First, Middle, Last) Ernest Hardesty				18. Mother's Name (First, Middle, Maiden Surname) Lillian Sansbury					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Julia Hardesty/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3043 Solomons Island Rd. Edgewater, MD 21037					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery		20c. Location - City or Town, State 2-5-99 Annapolis, Maryland					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. Aspiration Pneumonia</p> <p>b. Chronic congestive heart failure</p> <p>c. Ischemic cardiomyopathy.</p> <p>d. Coronary atherosclerotic heart disease</p> </div> <div style="width: 10%; text-align: center;"> <p>3 wks</p> <p>2 months</p> <p>2 months</p> <p>years</p> </div> </div>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number NO 8314		29d. Date signed (Month, Day, Year) 2/3/99				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) George P. Kalas Funeral Home 205 Ridgely Ave. Annapolis MD 21401										
State Registrar	31. Date filed (Month, Day, Year) FEB 04 1999				32. Registrar's Signature 					

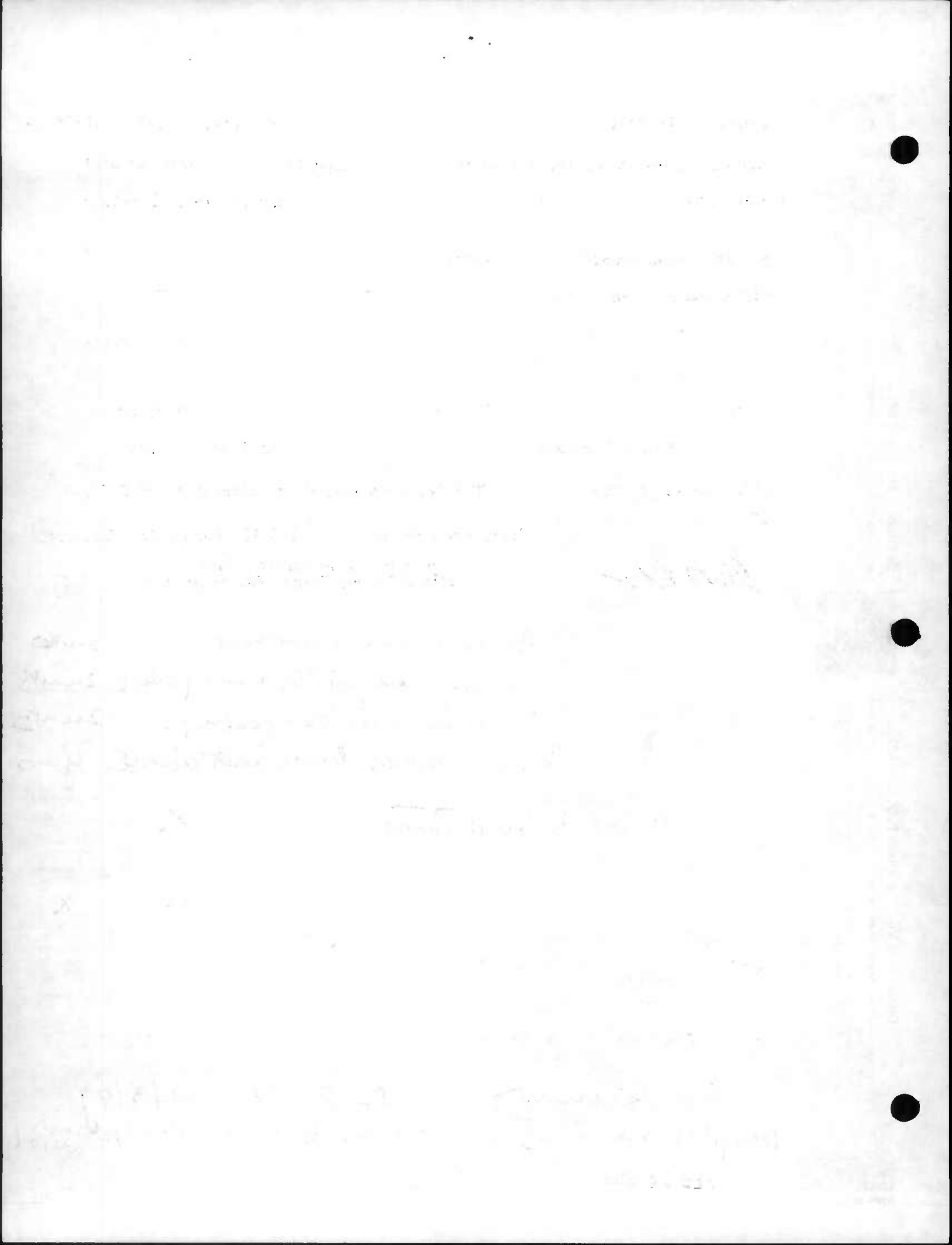
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04745

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mabel Elizabeth Heninger

2. Date of Death

Month Day Year

February 1, 1999

3. Time of Death

11 PM

4a. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-34-2222

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov 10, 1914

9. Birthplace (State or Foreign Country)

Wyoming

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

707 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Emmett Clarence Kauffman

18. Mother's Name (First, Middle, Maiden Surname)

Annie E. Yarnell

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Lewis / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

498 Old Orchard Circle, Millersville, MD 21108

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

Feb 5 1999

20c. Location - City or Town, State

Elkridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sarcoma, spindle cell

Approximate Interval Between Onset and Death

uncertain

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Phillip Stone 711 Maiden Choice Lane, Baltimore MD 21228

31. Date filed (Month, Day, Year)

FEB 03 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #5 Per FH,6771,5/24/99dhb

Certificate of Death

Reg. No.

99 04746

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred Waskom Herndon				2. Date of Death Month Day Year January 29 1999		3. Time of Death 6:30 PM						
	4a. Facility Name (If not Institution, give street and number) Chesapeake Future Care Center				4b. City, Town, or Location of Death Arnold		4c. County of Death Anne Arundel						
Funeral Director	5. Social Security Number 577-00-0894 577-03-1224		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 3, 1915	9. Birthplace (State or Foreign Country) Wash., D.C.					
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State Md.	10b. County Anne Arundel	10c. City, Town or Location Annapolis				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	10e. Street and Number 84 Old Mill Bottom Rd.				10f. Zip Code 21401		10g. Citizen of What Country? USA						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Analyst				16b. Kind of Business/Industry U.S. Commerce Dept.						
	17. Father's Name (First, Middle, Last) Albert J. Waskom				18. Mother's Name (First, Middle, Maiden Surname) Julia B. O'Connor								
	19a. Informant's Name/Relationship (Type, Print) Grover W. Herndon /husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 84 Old Mill Bottom Rd. Annapolis, Md. 21401								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 2-4-99		20c. Location - City or Town, State Suitland, Maryland						
	21. Signature of Funeral Service Licensee C-Brian Powell				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Dementia</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Due to (or as a consequence of): Alzheimer's disease</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Dementia	Approximate Interval Between Onset and Death	b. Due to (or as a consequence of): Alzheimer's disease	c. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Dementia	Approximate Interval Between Onset and Death											
	b. Due to (or as a consequence of): Alzheimer's disease												
	c. Due to (or as a consequence of):												
	d. Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Colon Cancer Fx. (L) arm						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier Joseph N. Friend M.D.				29c. License number D17965		29d. Date signed (Month, Day, Year) 2/2/99							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph N. Friend 205 Ridgely Ave Annapolis, Md 21401													
31. Date filed (Month, Day, Year) FEB 02 1999		32. Registrar's Signature B. Sparks											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 04747

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Luella T. Hale				2. Date of Death Month Day Year February 1, 1999				3. Time of Death 2:45 A.M.	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 063-18-5423		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 17, 1922		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent				10a. State Maryland				10b. County Anne Arundel	
To Be Completed by Funeral Director	10c. City, Town or Location Edgewater				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	10e. Street and Number 172 Calhoun Street				10f. Zip Code 21037				10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper				16b. Kind of Business/Industry Education	
	17. Father's Name (First, Middle, Last) Merton Tooley				18. Mother's Name (First, Middle, Maiden Surname) Grace Butcher					
	19a. Informant's Name/Relationship (Type, Print) David C. Hale/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 172 Calhoun Street Edgewater, Maryland 21037					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 2/1/99		20c. Location - City or Town, State Alexandria, Virginia			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GASTROINTESTINAL BLEEDING Due to (or as a consequence of): b. PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 4 DAYS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ADVANCED ALZHEIMER'S DEMENTIA				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number MD D39037		
29d. Date signed (Month, Day, Year) 2/1/99										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOUGLAS S. MITCHELL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS MD 21401										
State Registrar	31. Date filed (Month, Day, Year) FEB 02 1999				32. Registrar's Signature 					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 04748**  
**Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

**OIE JONES**

2. Date of Death

**FEB 3 1999 5:51 AM**

3. Time of Death

**5:51 AM**

4a. Facility Name (If not institution, give street and number)

**Loch Raven Genesis Senior Center**

4b. City, Town, or Location of Death

**Baltimore**

4c. County of Death

Funeral  
Director

5. Social Security Number

**220-10-6003**

6. Sex

**1 M 2 F**

7. Age (In yrs. last birthday)

**84**

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

**April 20, 1914**

9. Birthplace (State or Foreign Country)

**Washington**

Usual Residence of Decedent

10a. State

**Maryland**

10b. County

**Cecil**

10c. City, Town or Location

**Perryville**

10d. Inside City Limits

**1 Yes 2 No**

10e. Street and Number

**80 Patterson Avenue**

10f. Zip Code

**21903**

10g. Citizen of What Country?

**United States**

11. Marital Status

**1 Never Married 2 Married**

**3 Widowed 4 Divorced**

12. Was Decedent Ever In U.S. Armed Forces?

**1 Yes 2 No**

**If Yes, Give Year or Dates: US Navy WWII**

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

**1 Yes 2 No Specify:**

14. Race - American Indian, Black, White, etc.

**Specify: White**

15. Decedent's Education (Specify only highest grade completed)

**Elementary/Secondary (0-12)**

**5**

**College (1-4 or 5+)**

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

**Stationary Engineer**

16b. Kind of Business/Industry

**Veterans**

**Medical Center**

17. Father's Name (First, Middle, Last)

**Henry Jones**

18. Mother's Name (First, Middle, Maiden Surname)

**Helga Helgeson**

19e. Informant's Name/Relationship (Type, Print)

**Ida Passion / Friend**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**226 Bard Cameron Road, Rising Sun, MD 21911**

20e. Method of Disposition

**1 Burial 2 Cremation 3 Removal from State**

**4 Donation 5 Other (Specify)**

20b. Place of Disposition (Name of cemetery, crematory or other place)

**Wicomico Memorial Park**

Date

**Feb. 8**

20c. Location - City or Town, State

**Salisbury, Maryland**

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

**Crouch Funeral Home**

**127 South Main Street, North East, MD 21901**

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

**Pneumonia**

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

**Tracheobronchitis**

Due to (or as a consequence of):

**Subacute pneumonia**

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Dementia**

23b. Did tobacco use contribute to the cause of death?

**1 Yes 2 No 3 Probably 4 Unknown**

24e. Was an autopsy performed?

**1 Yes 2 No**

24b. Were autopsy findings available prior to completion of cause of death?

**1 Yes 2 No**

25. Was case referred to medical examiner?

**1 Yes 2 No**

26. Place of Death (Check only one)

Hospital:

**1 Inpatient 2 ER/Outpatient 3 DOA**

Other:

**4 Nursing Home 5 Residence 6 Other (Specify)**

27. Manner of Death

**1 Natural 2 Accident**

**3 Suicide 4 Homicide**

**5 Pending investigation**

**6 Could not be determined**

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

**M**

28c. Injury at Work?

**1 Yes 2 No**

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

**1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.**

**2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.**

29b. Signature and title of certifier

**Blad M. Sparks**

29c. License number

**D41901**

29d. Date signed (Month, Day, Year)

**2-3-99**

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

**Blad M. Sparks MD, 3006 Northern Parkway, Baltimore, MD 21214**

31. Date filed (Month, Day, Year)

**FEB 04 1999**

32. Registrar's Signature

**Blad M. Sparks**

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04749

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PHILLIP ETHELBERT JONES</b>				2. Date of Death Month <b>02</b> / Day <b>03</b> / Year <b>1999</b>		3. Time of Death <b>5:05PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Fort Washington Hospital</b>				4b. City, Town, or Location of Death <b>Fort Washington</b>		4c. County of Death <b>Prince Georges</b>	
Funeral Director	5. Social Security Number <b>440-14-4345</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>October 24, 1923</b>	
	9. Birthplace (State or Foreign Country) <b>Oklahoma</b>		10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Waldorf</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3906 Accokeek Road</b>		10f. Zip Code <b>20601</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Date: <b>1943-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Federal Government</b>				
17. Father's Name (First, Middle, Last) <b>Phillip E. Jones</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eloise Jones</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Dorothy A. Jones- Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3906 Accokeek Road Waldorf, Maryland 20601</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. Marys Piscataway Cem.</b>		20c. Location - City or Town, State <b>Clinton, Maryland</b>		20d. Date <b>Feb. 9, 1999</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Adams Funeral Home Aquasco, Maryland 20608</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Cardiorespiratory arrest</b> Due to (or as a consequence of):</p> <p>b. <b>Coronary artery disease, cardiomyopathy</b> Due to (or as a consequence of):</p> <p>c. <b>Renal failure. Diabetes</b> Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 65%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>MD14619</b>		29d. Date signed (Month, Day, Year) <b>2/4/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. Mahmud Mohamadi 6130 Oxon Hill Rd Oxon Hill Maryland 20745</b>								
31. Date filed (Month, Day, Year) <b>FEB 08 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04750

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ERNEST LYNWOOD JOHNSON SR.</b>				2. Date of Death Month Day Year <b>JANUARY 26, 1999</b>		3. Time of Death <b>7:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>411 MILLWOOF DRIVE</b>				4b. City, Town, or Location of Death <b>CAPITAL HEIGHTS</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>577-03-8708</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MARCH 22, 1910</b>		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>PRINCE GEORGES</b>		10c. City, Town or Location <b>CAPITAL HEIGHTS</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>411 MILLWOOF DRIVE</b>				10f. Zip Code <b>20743</b>		10g. Citizen of What Country? <b>UNITED STATES</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ELECTRICAL ENGINEER</b>		16b. Kind of Business/Industry <b>DISTRICT GOVERNMENT</b>		
17. Father's Name (First, Middle, Last) <b>PARKER JOHNSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MELINDA BROWN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>MARGARET NESMITH FIANCÉE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>411 MILLWOOF DRIVE, CAPITAL HEIGHTS MARYLAND 20743</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FORT LINCOLN CREMATORY</b>		20c. Location - City or Town, State <b>1-29-99 BRENTWOOD, MARYLAND</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>FORT LINCOLN FUNERAL HOME, INC. 3401 BLADENSBURG RD, BRENTWOOD MARYLAND 20722</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>LUNG CANCER</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last.  b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>18364</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 28, 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>STEPHEN E. GORDON 1160 VARNUM STREET, N.E. SUITE 114 WASHINGTON D.C. 20017</b>								
31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 69760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended # 19b, P.G. GC, State of Maryland / Department of Health and Mental Hygiene  
P.G.Co. Certificate of Death

Reg. No. 99 04751

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>ANNA V. JOSEPH</b>				2. Date of Death Month Day Year <b>JAN 29, 1999</b>		3. Time of Death <b>10:00 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
5. Social Security Number <b>577-09-4155</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 9, 1915</b>	
9. Birthplace (State or Foreign Country) <b>WASHINGTON, D.C.</b>		10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>719 MAIDEN JOYCE LANE APT BR322</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Collega</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OFFICE SECRETARY</b>		16b. Kind of Business/Industry <b>AMERICAN RED CROSS</b>		17. Father's Name (First, Middle, Last) <b>THOMAS RAFTERY</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>ELIZABETH CONWAY</b>		19a. Informant's Name/Relationship (Type, Print) <b>MARGARET GILLAM (SISTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>333 WOODSHIRE RD, COLLINSVILLE, Virginia 24078</b>		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FORT LINCOLN CREMATORY</b>		20c. Location - City or Town, State <b>1-31-99 BRENTWOOD, MARYLAND</b>		21. Signature of Funeral Service Licensee <b>Ramon Gutierrez</b> MO0907		22. Name and Address of Facility <b>FORT LINCOLN FUNERAL HOME INC. 3401 BLADENSBURG RD BRENTWOOD MARYLAND 20722</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CECAL PERFORATION</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		23c. Approximate Interval Between Onset and Death <b>2 DAYS</b>		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year) <b>1999</b>		28b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>MEURA M.D.</b>		29c. License number <b>P-10883</b>		29d. Date signed (Month, Day, Year) <b>JAN 29, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type) <b>ST. AGNES HOSPITAL, BALTIMORE, MD</b>		31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>		32. Registrar's Signature <b>[Signature]</b>		33. State Registrar	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME ANNA JOSEPH

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State of Maryland / Department of Health and Mental Hygiene 99 04752

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DONALD HORACE JOHNSON SR</b>				2. Date of Death Month Day Year <b>February 1 1999</b>		3. Time of Death <b>1013</b>	
	4a. Facility Name (If not Institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>452-66-1356</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>59</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>December 15, 1939</b>	
	9. Birthplace (State or Foreign Country) <b>Delaware</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>	
Usual Residence of Decedent		10d. Inside City Limits <b>1 Yes 2 No</b>		10e. Street and Number <b>320 Whitman Ave.</b>		10f. Zip Code <b>21801</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No 57-61</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 Yes 2 No Specify:</b>		
14. Race - American Indian, Black, White, etc. <b>Specify: White</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 College (1-4 or 5+) -</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Fork Lift Operator</b>		16b. Kind of Business/Industry <b>American Mirex</b>		
17. Father's Name (First, Middle, Last) <b>Horace Johnson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edith Howard</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Cathryn D. Johnson/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>320 Whitman Ave., Salisbury, MD 21801</b>				
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cemetery</b>		20c. Date <b>2/5/99</b>		20d. Location - City or Town, State <b>Hurlock, MD</b>		
21. Signature of Funeral Service Licensee <b>David H. Thompson</b>		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>ASCVD</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>DM</b> <b>CAD</b> <b>Hyperlipidemia</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DM</b> <b>CAD</b> <b>Hyperlipidemia</b>						23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>		
24a. Was an autopsy performed? <b>1 Yes 2 No</b>						24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>		
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>						
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>								
29b. Signature and title of certifier <b>Chm S.D. D.O. D.M.E.</b>				29c. License number <b>1550497</b>		29d. Date signed (Month, Day, Year) <b>2/1/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Christopher Snyder D.O.</b>								
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>				32. Registrar's Signature <b>Sparks</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04753

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RAYMOND POTTER JEROME</b>				2. Date of Death Month <b>FEBRUARY</b> Day <b>06</b> , Year <b>1999</b>		3. Time of Death <b>10:30 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>MALCOLM GROW MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>CAMP SPRINGS</b>		4c. County of Death <b>PRINCE GEORGES'S</b>	
Funeral Director	5. Social Security Number <b>056-32-8397</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APRIL 11, 1941</b>	
	9. Birthplace (State or Foreign Country) <b>NEW YORK</b>		10a. State <b>MARYLAND</b>		10b. County <b>CALVERT</b>		10c. City, Town or Location <b>LUSBY</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>12026 SETTLERS TRAIL</b>		10f. Zip Code <b>20657</b>		10g. Citizen of What Country? <b>U. S. A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1957 -</b> If Yes, Give Year or Dates: <b>1980</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>WARRANT OFFICER</b>		16b. Kind of Business/Industry <b>U. S. ARMY</b>				
17. Father's Name (First, Middle, Last) <b>CLARENCE JEROME</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARIE POTTER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>BARBARA M. JEROME / WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12026 SETTLERS TRAIL LUSBY, MARYLAND 20657</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LEE CREMATORY</b>		20c. Location - City or Town, State <b>FEBRUARY 7, 1999 CLINTON, MARYLAND</b>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MD BLVD. OWINGS, MARYLAND 20736</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>HEPATO-RENAL FAILURE</b> Due to (or as a consequence of): b. <b>METASTATIC LUNG CANCER</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  <b>MAJ, USAF</b>		29c. License number <b>J 1858 TEXAS</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 06, 1999</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CATHERINE BARD, MAJ, USAF, MC</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>89 MDG/1050 W PERIMETER RD ANDREWS AIR FORCE BASE, MD 20762-6600</b>						
31. Date filed (Month, Day, Year) <b>FEB 09 1999</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: RAYMOND P JEROME

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04754

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ELIZABETH MAE DIEHL JACOBS

2. Date of Death

Month Day Year  
FEBRUARY 6, 1999

3. Time of Death

3:43 PM

4a. Facility Name (If not institution, give street and number)

GLADE VALLEY NURSING &amp; REHABILITATION

4b. City, Town, or Location of Death

WALKERSVILLE

4c. County of Death

FREDERICK

5. Social Security Number

313-30-7041

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT 9, 1912

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9600 Swallow Point Way

10f. Zip Code

20866

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Customer Service Trainer

16b. Kind of Business/Industry

Super-Market

17. Father's Name (First, Middle, Last)

Samuel C. Diehl

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Dean

19a. Informant's Name/Relationship (Type, Print)

Patricia Mills / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9600 Swallow Point Way, Gaithersburg, MD 20866

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Highland Memorial Park

Date

2/12/99

20c. Location - City or Town, State

Johnston, Rhode Island

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.  
1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Congestive Heart Failure

Due to (or as a consequence of):

b.

Coronary Artery Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 day  
years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D26519

29d. Date signed (Month, Day, Year)

FEB 8 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen J. Gilson MD 1475 TWINEY AVE FRED MD 21702

31. Date filed (Month, Day, Year)

FEB 08 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

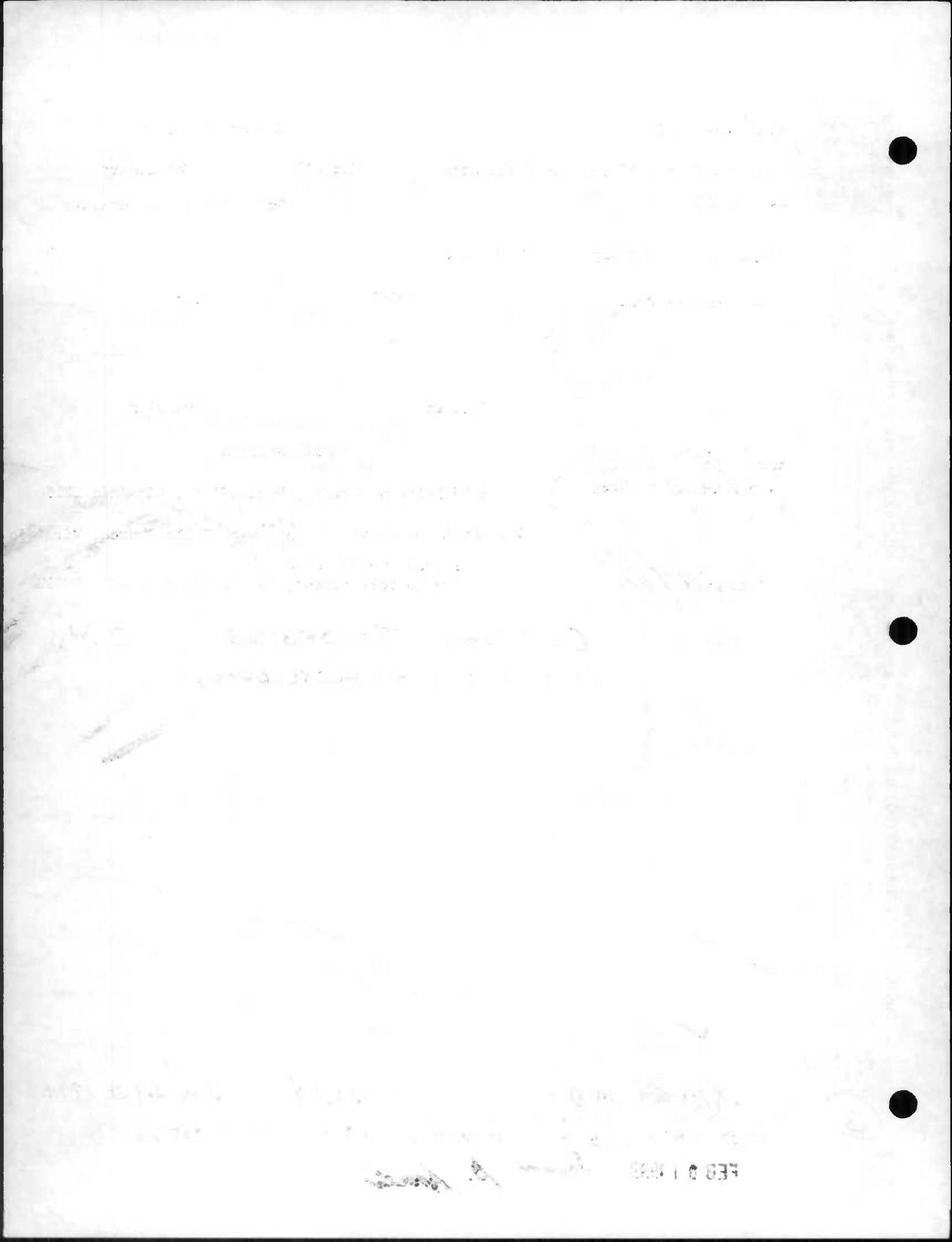
Reg. No.

99 04755

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elsa Sara Klein</b>				2. Date of Death Month Day Year <b>January 30, 1999</b>		3. Time of Death <b>5:25 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>The Hebrew Home of Greater Washington</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>216-46-7754</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>95</b> Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) <b>October 16, 1903</b>	9. Birthplace (State or Foreign Country) <b>Hungary</b>	
	Usual Residence of Decedent							
10e. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>6121 Montrose Road</b>				10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Education</b>		
17. Father's Name (First, Middle, Last) <b>Marton Stark</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Fannie Solomon</b>				
19a. Informant's Name/Relationship (Type, Print) <b>June Pensler/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6615 Palamino Street, Springfield, Virginia 22150</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King David Cemetery</b>		20c. Date <b>Feb. 03, 1999</b>		20d. Location - City or Town, State <b>Falls Church, Virginia</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Takoma Funeral Home</b> <b>254 Carroll Street, NW, Washington, DC 20012</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CEREBRAL THROMBOSIS</b> Due to (or as a consequence of): <b>b. GENERALISED ATHEROSCLEROSIS</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Approximate Interval Between Onset and Death <b>2 DAYS</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>D. D. Patel M.D.</b>						
		29c. License number <b>D18084</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 30, 1999</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>D. D. PATEL, M.D., 6121 MONTROSE RD, ROCKVILLE, MD 20852</b>								
31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene 99 04756

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lethia W. Knox				2. Date of Death Month Day Year JANUARY 27, 1999		3. Time of Death 0530			
	4a. Facility Name (If not institution, give street and number) 6804 GREIG STREET #102				4b. City, Town, or Location of Death LANDOVER		4c. County of Death PRINCE GEORGES			
Funeral Director	5. Social Security Number 578-22-3885		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 17, 1923	9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's		10c. City, Town or Location Seat Pleasant			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 6804 Greig Street #102			10f. Zip Code 20743		10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse		16b. Kind of Business/Industry Holy Cross Hospital					
	17. Father's Name (First, Middle, Last) John R. Knox				18. Mother's Name (First, Middle, Maiden Surname) Louise Wright					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gail L. Cunningham (Niece)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 Annapolis Avenue Landover, Maryland 20785					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory, Inc.		Date 1/30/99	20c. Location - City or Town, State Beltsville, Maryland				
	21. Signature of Funeral Service Licensee <i>James C. Henderson</i>				22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)             1. <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>  <i>Due to consequences of:</i>  <b>AND EMPHYSEMA</b>            Due to (or as a consequence of):            c. _____            Due to (or as a consequence of):            d. _____         </p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>James C. Henderson</i> MDE				29c. License number D33954		29d. Date signed (Month, Day, Year) JANUARY 27, 1999			
State Registrar	30. Name and address of person who completed cause of death (item 28a) (Type, Print) MARIO F. GOLLE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785									
	31. Date filed (Month, Day, Year) FEB 01 1999				32. Registrar's Signature <i>James A. Spaulding</i>					

Baltimore, Maryland 21215-0020

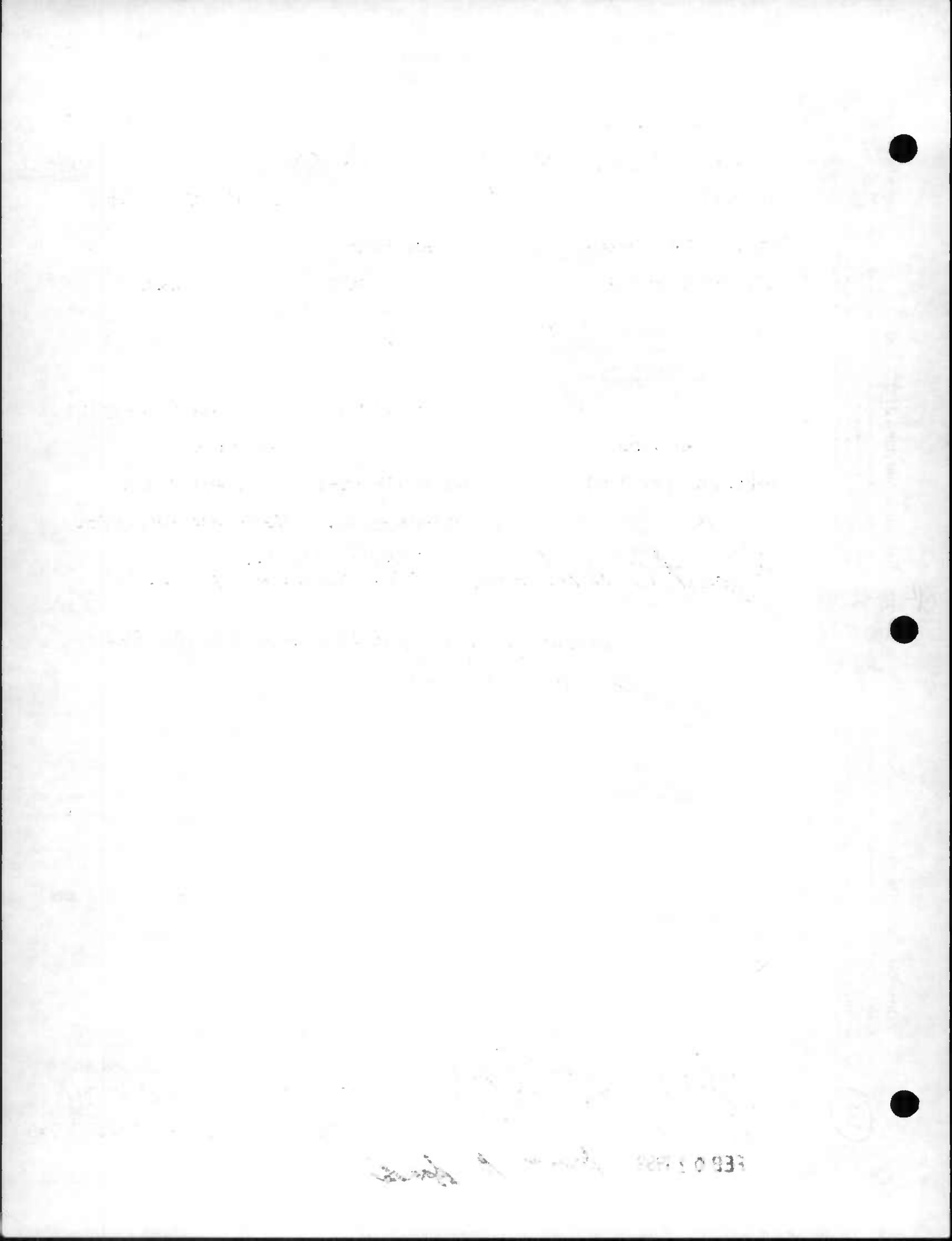
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04757

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Koory, Sr.				2. Date of Death Month Day Year February 1, 1999		3. Time of Death 4:50AM	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-32-2440		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 76	8. Date of Birth (Month, Day, Year) Nov. 11, 1922		9. Birthplace (State or Foreign Country) Washington, D.C.	
	Usual Residence of Decedent							
10a. State Maryland		10b. County Charles		10c. City, Town or Location Waldorf			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 5128 Beaugregory Ct.				10f. Zip Code 20603		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean War		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Government			16b. Kind of Business/Industry GSA	
17. Father's Name (First, Middle, Last) Abdo Koory				18. Mother's Name (First, Middle, Maiden Surname) Niza Dayeh				
19a. Informant's Name/Relationship (Type, Print) Susan Koory/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 732 Eskimo Hill Rd. Stafford, VA. 22554				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State Suitland, MD.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD. 20745				
23a. Part I. Enter the disease, or complications, which caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line.  <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. Congestive heart failure Due to (or as a consequence of):</p> <p>b. Acute myocardial Infarction Due to (or as a consequence of):</p> <p>c. Coronary Artery disease Due to (or as a consequence of):</p> <p>d. Mitral regurgitation</p> </div> <div> <p>Approximate Interval Between Onset and Death</p> <p>Admitted on 1/13/99</p> <p>Expired at 4:50AM on 2/1/99</p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <p>Acute lower gastrointestinal bleed</p> <p>Renal Failure.</p> <p>Atrial Fibrillation.</p>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D35295		29d. Date signed (Month, Day, Year) February 1, 1999		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Satish N. Jumani, M.D. #2 St. Patricks Dr. #208 Waldorf, MD. 20603								
31. Date filed (Month, Day, Year) FEB 02 1999				32. Registrar's Signature 				

To Be Completed by Funeral Director

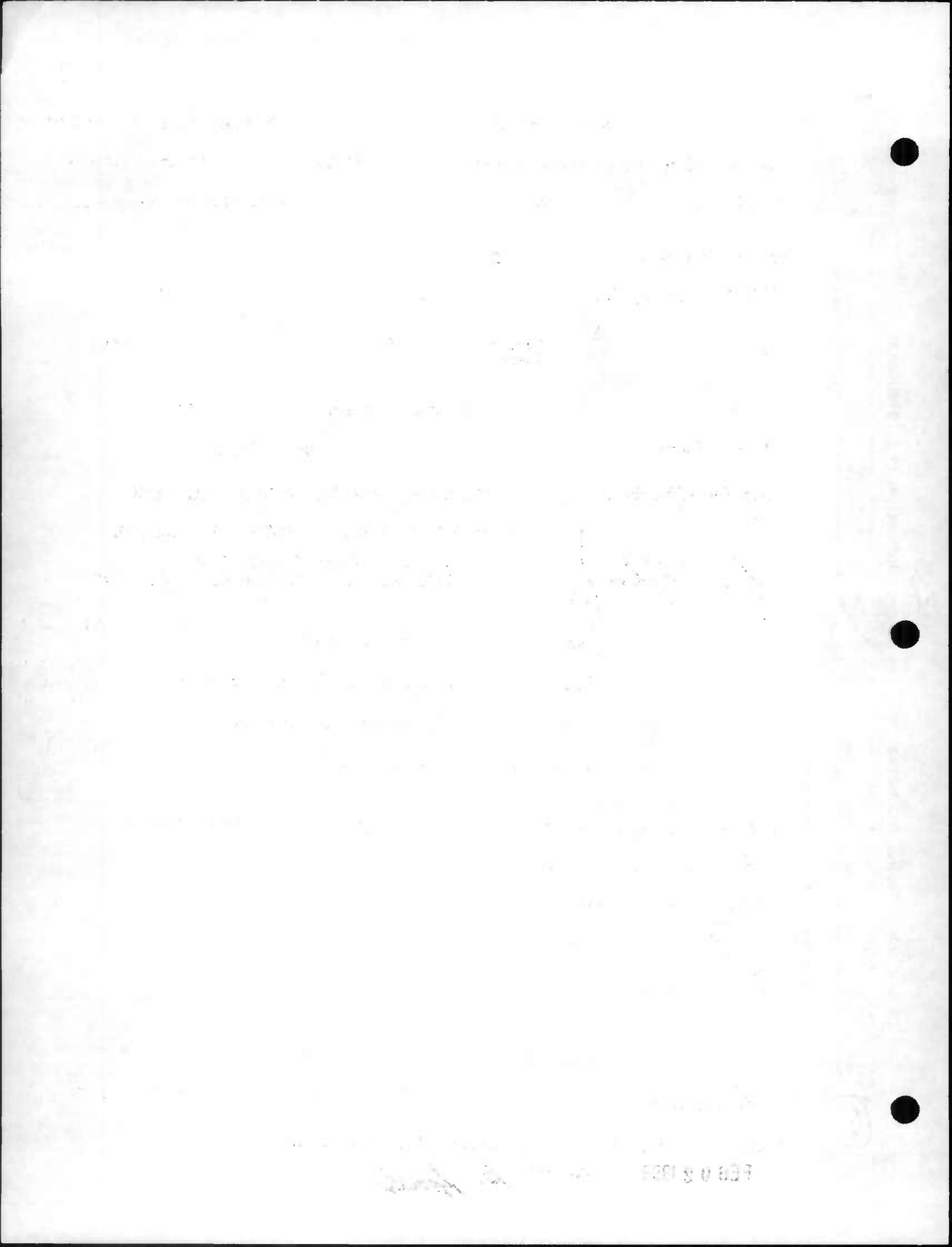
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04758

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNIE R. KNOX				2. Date of Death Month Day Year FEB. 2, 1999		3. Time of Death 10:43 AM	
	4a. Facility Name (If not institution, give street and number) 5403 LIVINGSTON TERRACE				4b. City, Town, or Location of Death OXON HILL		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 240-86-1742		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) MAY 5, 1950	
	9. Birthplace (State or Foreign Country) NORTH CAROLINA		10a. State MARYLAND		10b. County PRINCE GEORGES		10c. City, Town or Location OXON HILL	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 5403 LIVINGSTON TERRACE		10f. Zip Code 20745		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSES ASSISTANT		16b. Kind of Business/Industry HOME HEALTH CARE			
	17. Father's Name (First, Middle, Last) STONEY KNOX				18. Mother's Name (First, Middle, Maiden Surname) JUANITA Unknown			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) WILLIE D. KNOX SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1550 CLARENDON BLVD, ARLINGTON VA 22209			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FORT LINCOLN CEMETERY		20c. Location - City or Town, State 2-8-99 BRENTWOOD, MARYLAND		21. Signature of Funeral Service Licensee Rain Dattney MO0907	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility FORT LINCOLN FUNERAL HOME INC. 3401 BLADENSBURG RD, BRENTWOOD MD 20722				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypertensive Arteriosclerotic Due to (or as a consequence of): X Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):			
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? X Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? X Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? X Yes 2 <input type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death X Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check and one) X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier J. A. Locke MD			
	29c. License number O.C.M.E				29d. Date signed (Month, Day, Year) FEB. 3, 1999			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. A. Locke MD 111 Penn Street, Baltimore, Maryland 21201				31. Date filed (Month, Day, Year) FEB 05 1999			
	32. Registrar's Signature [Signature]				33. Date of Death FEB. 2, 1999			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04759

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HOWARD JOHN KOTZ SR.

2. Date of Death

FEBRUARY 4, 1999

3. Time of Death

00:10

4a. Facility Name (If not institution, give street and number)

CALVERT MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

PRINCE FREDERICK

4c. County of Death

CALVERT

Funeral  
Director

5. Social Security Number

139-12-1636

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUGUST 12, 1912

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CALVERT

10c. City, Town or Location

CHESAPEAKE BEACH

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4019 28th STREET

10f. Zip Code

20732

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FEDERAL EMPLOYEE

16b. Kind of Business/Industry

HUD/U.S. GOVERNMENT

17. Father's Name (First, Middle, Last)

PAUL KOTZ

18. Mother's Name (First, Middle, Maiden Surname)

FREIDA SCHMIDT

19a. Informant's Name/Relationship (Type, Print)

HOWARD J. KOTZ, JR. / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4019 28th STREET CHESAPEAKE BEACH, MARYLAND 20732

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GREENWOOD CEMETERY

Date

FEBRUARY 08, 1999

20c. Location - City or Town, State

HAMILTON TOWNSHIP, NJ

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LEE FUNERAL HOME CALVERT, P.A.

8125 SOUTHERN MD BLVD. OWINGS, MARYLAND 20736

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

b. Chronic Obstructive Lung Disease

Due to (or as a consequence of):

year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Cardiovascular Disease

Cerebrovascular Insufficiency.

Permanent Heart Pacemaker

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gerald P. Sterner M.D.

29c. License number

D17245

29d. Date signed (Month, Day, Year)

Feb. 4, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Gerald P Sterner, M.D. Owings, Maryland 20736

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04760

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Thelma V. Kellar</b>				2. Date of Death Month <b>Feb.</b> Day <b>2,</b> Year <b>1999</b>		3. Time of Death <b>7:10A.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Citizens Nursing Home</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>214-36-9233</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug 2, 1913</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10e. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
Usual Residence of Decedent		10e. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>1900 Rosemont Avenue</b>		10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own home</b>				
17. Father's Name (First, Middle, Last) <b>Elbert Honaker</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Vergy Cook</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Turner</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6423 Mountindale Rd., Thurmont, Maryland 21788</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resthaven Memorial Gardens</b>		Date <b>2/3/99</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stauffer Funeral Homes, P. A. 1621 Opossumtown Pike, Frederick, Md. 21702</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>CVA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
Approximate Interval Between Onset and Death <b>10 days</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D-13971</b>		29d. Date signed (Month, Day, Year) <b>2/2/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>300 W 9th St, Frederick MD 21701</b>								
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04761

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gus George Koste</b>				2. Date of Death Month Day Year <b>Feb. 4, 1999</b>		3. Time of Death <b>7:15 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>25000 Pealiquor Rd.</b>				4b. City, Town, or Location of Death <b>Denton</b>		4c. County of Death <b>Caroline</b>	
Funeral Director	5. Social Security Number <b>218-16-5356</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 4, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>U.S.A.</b>		10a. State <b>Maryland</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Denton</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>25000 Pealiquor Rd.</b>		10f. Zip Code <b>21629</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Law Enforcement Officer</b>		16b. Kind of Business/Industry <b>Law Enforcement</b>				
17. Father's Name (First, Middle, Last) <b>George Koste</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Nichols</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Bessie Chapis Koste - wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>25000 Pealiquor Rd., Denton, MD 21629</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cambridge Crematory</b>		20c. Date <b>2-5-99</b>		20d. Location - City or Town, State <b>Cambridge, MD</b>		
21. Signature of Funeral Service Licensee <i>Curran-Bromwell</i>				22. Name and Address of Facility <b>Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613</b>				
23a. (Part I) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hypostatic pneumonia</b> Due to (or as a consequence of):  <b>b. Alzheimer's disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>Uncertain</b>  <b>Uncertain</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>None</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Robert W. Trever, M.D.</b>				29c. License number <b>D10938</b>		29d. Date signed (Month, Day, Year) <b>Feb 4, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert W. Trever, M.D., 7696 Ocean Gateway, Easton, MD 21601</b>								
31. Date filed (Month, Day, Year) <b>FEB 5 1999</b>		32. Registrar's Signature <i>Benita S. Sparks</i>						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04762

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ronald E. Lord</b>				2. Date of Death Month Day Year <b>February 5, 1999</b>		3. Time of Death <b>3:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>75 Andrea Dr.</b>				4b. City, Town, or Location of Death <b>Chesapeake City</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>222-28-1404</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>55</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 6, 1944</b>	
	9. Birthplace (State or Foreign Country) <b>Pa.</b>		10a. State <b>Md.</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Chesapeake City</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>75 Andrea Dr.</b>		10f. Zip Code <b>21915</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Restaurant Owner</b>		16b. Kind of Business/Industry <b>Retail Food Service</b>		17. Father's Name (First, Middle, Last) <b>Marvin Lord</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Ann Grace Lord</b>		19a. Informant's Name/Relationship (Type, Print) <b>Edie Wardrop</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>75 Andrea Dr. Chesapeake City, Md. 21915</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R.A. Ferris &amp; Co.</b>		20c. Date <b>2/8/99</b>		20d. Location - City or Town, State <b>West Chester, Pa.</b>		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility <b>R.T. Foard Funeral Home, P.A. 318 George St., Chesapeake City, Md. 21915</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Lung Cancer</b>		23b. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death <b>3 years</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>H. Farkas, MD</b>		29c. License number <b>D15314</b>		
29d. Date signed (Month, Day, Year) <b>February 6, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Henery Farkas 111 W. High St., Elkton, Md. 21921</b>		31. Date filed (Month, Day, Year) <b>FEB 08 1999</b>		32. Registrar's Signature 		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

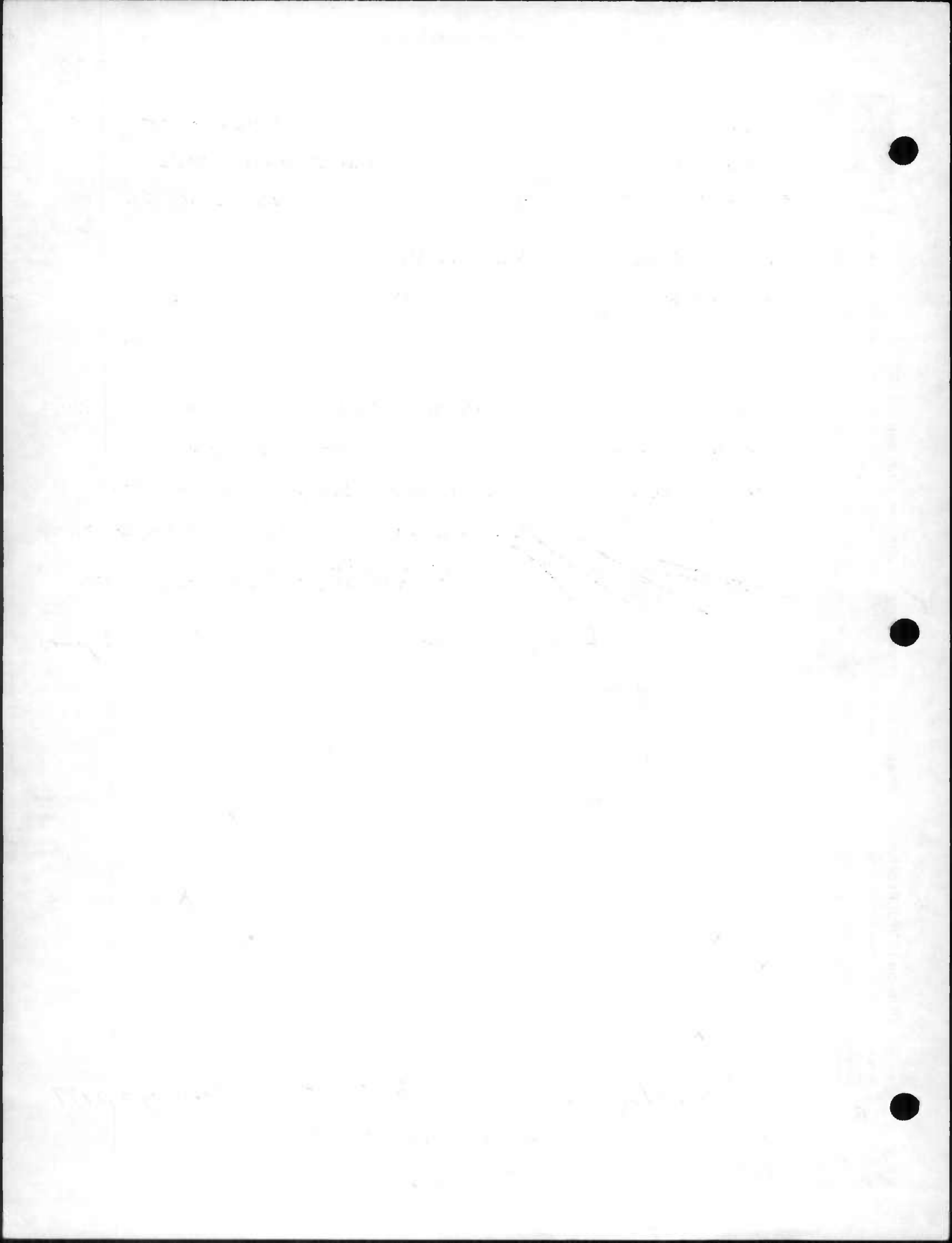
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





99 04763

DHHM 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 06761

CARLOS  
LUCEROPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

CARLOS LUCERO

2. Date of Death  
Month Day Year  
FEBRUARY 2, 19993. Time of Death  
1:28 P.M.

4a. Facility Name (If not institution, give street and number)

1724 WOODLAWN DRIVE

4b. City, Town, or Location of Death

WOODLAWN

4c. County of Death

BALTIMORE

5. Social Security Number

UNKNOWN

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

21 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 30, 1977

9. Birthplace (State or Foreign Country)

Guatemala

Usual Residence of Decedent

10a. State

Md.

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7126 Rolling Ven Rd. Apt. D

10f. Zip Code

21244

10g. Citizen of What Country?

Guatemala

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Guatemalan

14. Race - American Indian, Black, White, etc.

Specify: Hispanic

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DishWasher

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Alejandro Lucero

18. Mother's Name (First, Middle, Maiden Surname)

Maria Esquibel

19a. Informant's Name/Relationship (Type, Print)

Jose V. Montoya Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14403 Black Horse Court Centreville, Va. 20120

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Family Cemetery

Date

02/11/99

20c. Location - City or Town, State

Jutiapa, Guatemala

21. Signature of Funeral Service Licensee

Wanda C. Bacon #887

22. Name and Address of Facility

W.H. Bacon Funeral Home  
3447 14th Street N.W. Washington, D.C. 20010

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Head Injuries  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

UNK

28b. Time of Injury

UNK M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Slipped falling down steps

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

OUTSIDE STAIRWELL

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1724 Woodlawn Dr, 21209

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wanda C. Bacon

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

FEBRUARY 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JASON LOCKE, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

\_\_\_\_\_

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04765

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

TEMPY BROOKS LEWIS

2. Date of Death

Month Day Year  
February 1, 1999

3. Time of Death

4:30 AM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

224-36-9398

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
February 21, 1933

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11102 Hudee Court

10f. Zip Code

20721

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Professor Of Dentistry

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Robert Adkins

18. Mother's Name (First, Middle, Maiden Surname)

Manor Lee Silver

19a. Informant's Name/Relationship (Type, Print)

Samuel R. Lewis/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11102 Hudee Court, Mitchellville, Maryland 200721

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

02/09 1999

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentie

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME  
7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic renal failure

4 years

Due to (or as a consequence of):

b. Diabetes mellitus

24 years

Due to (or as a consequence of):

c. Heart failure

10 years

Due to (or as a consequence of):

d. Anemia

35 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Permanent pacemaker

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Moustafa Shamma

29c. License number

D43690

29d. Date signed (Month, Day, Year)

February 1, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Moustafa Shamma MD Doctors Community Hospital 8118 Good Luck Road Lanham MD 20706

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Lewis, Tempy B.  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12





WRC

2-0762-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

MICHELLE L. LACEY AMEND ITEMS: #23 PART I 27 28A F PER MEO G783 5 3 00 WR

LACEY AMENDED ITEMS: 23a, 27, 28a per MOC813 111402 ss Certificate of Death

Reg. No.

99 04766

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Michelle Lorraine Lacey</b>		2. Date of Death Month Day Year <b>FEB. 09, 1999</b>		3. Time of Death <b>4:02 PM.</b>	
4a. Facility Name (If not institution, give street and number) <b>4 ALEXANDER CHASE APT. L</b>		4b. City, Town, or Location of Death <b>COCKEYSVILLE</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>163-56-0713</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>24</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 8, 1974</b>
9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>					
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Parkton COCKEYSVILLE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>208 Kaufman Rd. 4 ALEXANDER CHASE</b>		10f. Zip Code <b>21120 21152</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>	
16b. Kind of Business/Industry <b>N/A</b>		17. Father's Name (First, Middle, Last) <b>George W. Lacey III</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Marianne L. Fletcher</b>	
19a. Informant's Name/Relationship (Type, Print) <b>George W. Lacey III/Father</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>208 Kaufman Rd., Parkton, MD 21120</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. James Episcopal Church Cemetery</b>		20c. Location - City or Town, State <b>Monkton, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <b>PROBABLE ASPHYXIA</b> Due to (or as a consequence of):					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>FOUND: 2-9-99</b>		28b. Time of Injury <b>FOUND: 3:15 PM</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject Asphyxiated UNKNOWN</b>			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND: RESIDENCE</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>FOUND: 4L ALEXANDER CHASE COCKEYSVILLE, MARYLAND</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>FEB. 10, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>K. KOSKI 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 01767

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Gertrude Loesch

2. Date of Death

February 1, 1999

3. Time of Death

8:30 PM

4a. Facility Name (If not institution, give street and number)

Salisbury Center: Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, MD

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

127-10-0123

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

May 15, 1912

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

200 Civic Ave

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Lady

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Walter Innes

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Haug

19a. Informant's Name/Relationship (Type, Print)

Albert H. Loesch III/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

426 Virginia Ave., Salisbury, MD 21801

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Memorial Park

Date

2/6/99

20c. Location - City or Town, State

Paramus, NJ

21. Signature of Funeral Service Licensee

David H. Thompson

MO1051

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Diabetic vascular disease*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *COPD*  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*12-18 months*  
*9-12 months*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Hypertension*  
*CAD*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*William H. Robins*

29c. License number

D29349

29d. Date signed (Month, Day, Year)

2/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Robins, M.D. 1104 Healthway Dr., Salisbury, MD 21804

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

*Anna B Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Amended # 31, 2/2/99,  
Md., Allegany County

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04768

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patricia Ann Lowdermilk</b>				2. Date of Death Month <b>January</b> Day <b>27</b> Year <b>1999</b>		3. Time of Death <b>1600</b>		
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>		
Funeral Director	5. Social Security Number <b>217-76-9698</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>37</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 16, 1961</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Friendsville</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>293 Teets Road</b>				10f. Zip Code <b>21531</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cook</b>		16b. Kind of Business/Industry <b>Restaurant</b>			
17. Father's Name (First, Middle, Last) <b>Robert J. Lowdermilk</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine E. Detrick</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Robert J. &amp; Katherine Lowdermilk/Parents</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>293 Teets Road, Friendsville, MD 21531</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sand Spring Cem., Jan. 30, 1999</b>		Date <b>Jan. 30, 1999</b>		20c. Location - City or Town, State <b>Friendsville, MD</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Newman Funeral Homes, P.A. 179 Miller St., PO Box 275, Grantsville, MD 21536</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute C.V.A. - Brain edema</b> Due to (or as a consequence of): <b>b. Multiple sclerosis</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>6 hrs.</b> <b>10 years</b>	
Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. <b>weight loss of undetermined cause</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Mohammad Shakeri MD</b>			29c. License number <b>28932</b>		29d. Date signed (Month, Day, Year) <b>January 28, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MOHAMMAD SHA FIEI, 902 Saton DR. Cumberland, MD, 21502</b>									
31. Date filed (Month, Day, Year) <b>1-28-99 FEB 02 1999</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04769

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Dolores Link				2. Date of Death Month Day Year February 3, 1999		3. Time of Death 6:22 P.M.	
	4a. Facility Name (If not institution, give street and number) Manorcare Health Services Potomac				4b. City, Town, or Location of Death Potomac		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579 14 5912	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov 7, 1919	9. Birthplace (State or Foreign Country) PA	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County P.G.	10c. City, Town or Location Landover			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 1509 Columbia Ave			10f. Zip Code 20785		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary Library of Congress U.S. Government				18b. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) Porter Thomas Blankenship				18. Mother's Name (First, Middle, Maiden Surname) Mary Martin			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) C. Richard Pullen (Per Rep)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4155 Bristol Drive, Chesapeake Beach, MD 20732			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 9, 1999 Salisbury National Cemetery		20c. Location - City or Town, State Salisbury, NC			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	<div> <div> Immediate Cause (Final disease or condition resulting in death) </div> <div> Due to (or as a consequence of): </div> </div> <div> <div> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </div> <div> Due to (or as a consequence of): </div> </div>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D30484		29d. Date signed (Month, Day, Year) 2/5/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Charles Unosella, M.D. 4333 Old Branch Ave, Marlow Heights, Maryland 20748								
31. Date filed (Month, Day, Year) FEB 09 1999		32. Registrar's Signature 						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 04770**  
**Certificate of Death** Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <div style="text-align: center;">Thelma Margaret LAWSON</div>				2. Date of Death Month Day Year February 8, 1999		3. Time of Death 8:14 P.M.	
	4a. Facility Name (If not institution, give street and number) 100 Burgess Hill Way				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
<b>Funeral Director</b>	5. Social Security Number 579-01-1604		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth Month Day Year June 25, 1920	
	9. Birthplace (State or Foreign Country) Washington D. C.		10a. State Maryland		10b. County Frederick		10c. City, Town or Location 100 Burgess Hill Way, Apt. 301	
<b>To Be Completed by Funeral Director</b>	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 100 Burgess Hill Way, Apt. 301		10f. Zip Code 21702		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Florist and business woman		16b. Kind of Business/Industry Neon Sign Company			
	17. Father's Name (First, Middle, Last) Leaven Thomas Barrett				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Pfleigher			
	19a. Informant's Name/Relationship (Type, Print) Dorothy Ann Grenier/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5400 Boyer Mill Rd., New Market, MD 21774			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		20c. Date Feb. 8, 1999		20d. Location (City or Town, State) Smithsburg, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Keeney & Basford Funeral Home 106 East Church Street, Frederick, MD 21701					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="text-align: center;">e. <b>ASCVD</b> Due to (or as a consequence of):</div> <div style="text-align: center;">b.  Due to (or as a consequence of):</div> <div style="text-align: center;">c.  Due to (or as a consequence of):</div> <div style="text-align: center;">d.  Due to (or as a consequence of):</div>							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <div style="text-align: center;">Myelodysplasia</div>							
	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
<b>Physician /Medical Examiner</b>	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
<b>State Registrar</b>	29b. Signature and title of certifier 		29c. License number D35164		29d. Date signed (Month, Day, Year) February 8, 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Zarick, M.D., 1080 West Patrick Street, Frederick, MD 21703							
31. Date filed (Month, Day, Year) FEB 08 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04771

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wilma Geraldine Lambert				2. Date of Death Feb 8 1999		3. Time of Death 2:45AM	
	4e. Facility Name (If not institution, give street and number) Randolph Hills Nursing Home				4b. City, Town, or Location of Death Wheaton		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 261-16-2203		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) Oct 22, 1908	
	9. Birthplace (State or Foreign Country) Florida		10a. State Va		10b. County Shenandoah		10c. City, Town or Location Woodstock	
To Be Completed by Funeral Director	Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 149 Valley Vista Drive, Apt 119		10f. Zip Code 22664	
	10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ret. Waitress		16b. Kind of Business/Industry Marriott Corp.	
	17. Father's Name (First, Middle, Last) Horace Drew May		18. Mother's Name (First, Middle, Maiden Surname) Mae Lillian Hagan		19a. Informant's Name/Relationship (Type, Print) Cathy Lambert Walker Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4311 Mahan Road, Silver Spring, Md. 20906	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Omps Crematory		20c. Location - City or Town, State 2/11/99 Winchester, Va.		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility Dellinger Funeral Home, 157 N Main Street Woodstock, Va. 22664		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction		Approximate Interval Between Onset and Death instant			
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cerebrovascular Insufficiency; Hypertensive		Due to (or as a consequence of):					
	Due to (or as a consequence of):							
	Due to (or as a consequence of):							
	Due to (or as a consequence of):							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiovascular Disease; Congestive Heart Failure				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 			
	29c. License number D08944				29d. Date signed (Month, Day, Year) February 8, 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin C. Shargel, M.D. 3720 Farragut Avenue, Kensington, MD 20895							
	State Registrar	31. Date filed (Month, Day, Year) FEB 18 1999		32. Registrar's Signature 				



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State of Maryland / Department of Health and Mental Hygiene

99 04772

Amend. 6 2/2/99 SM AACO Health

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROYCE W. LAMB				2. Date of Death Month Day Year JAN. 31, 1999		3. Time of Death 8:00PM	
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 214 05 1558	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 2, 1904		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 1211 BAY RIDGE AVE.				10f. Zip Code 21403		10g. Citizen of What Country? UNITED STATES		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MEAT CUTTER		16b. Kind of Business/Industry FOOD INDUSTRY		
17. Father's Name (First, Middle, Last) ANDREW LAMB				18. Mother's Name (First, Middle, Maiden Surname) ANNIE C. WIGGINS				
19a. Informant's Name/Relationship (Type, Print) LYNDALL MAE WARD (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1211 BAY RIDGE AVE, ANNAPOLIS, MD. 21403				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HILLCREST CEMETERY		Date 02-03-99		20c. Location - City or Town, State ANNAPOLIS, MD.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility JOHN M. TAYLOR FUNERAL HOME, INC. 147 DUKE OF GLOUCESTER ST. ANNAPOLIS, MD. 21401				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>cardio pulmonary arrest</u> Due to (or as a consequence of): b. <u>coronary Artery disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 20 min 3 yrs								
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia</u>								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D48101		29d. Date signed (Month, Day, Year) 2/1/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donna Chambers MD 1833A Forest Dr. Annapolis MD 21401								
31. Date filed (Month, Day, Year) FEB 02 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04773

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Peggy Joyce Moore

2. Date of Death

Month Day Year  
February 3, 1999

3. Time of Death

1410

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

232-52-2931

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 4, 1935

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

76 Jones Chapel Road

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Material Foreman

16b. Kind of Business/Industry

Chrysler Corporation

17. Father's Name (First, Middle, Last)

Guy Allen Palmer

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Katherine Collins

19a. Informant's Name/Relationship (Type, Print)

Charles R. Moore/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

76 Jones Chapel Road, Elkton, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Cherry Hill  
Methodist Cemetery

Date

February 6,

1999

20c. Location - City or Town, State

Cherry Hill, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hicks Home for Funerals, P.A.

103 West Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Cancer of Lung with Metastasis  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

Months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D23322

29d. Date signed (Month, Day, Year)

2/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHEELMOHAN SACHDEV, MD. 118 North St, ELKton, md. 21921

31. Date filed (Month, Day, Year)

FEB 08 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04774

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ernest McCulley</b>				2. Date of Death Month Day Year <b>February 1, 1999</b>		3. Time of Death <b>0400</b>	
	4a. Facility Name (If not institution, give street and number) <b>1189 Leeds Road</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>413-09-7287</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 9, 1917</b>		9. Birthplace (State or Foreign Country) <b>Tennessee</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1189 Leeds Road</b>				10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Painter</b>		16b. Kind of Business/Industry <b>Mobile Home Manufacturing</b>		
17. Father's Name (First, Middle, Last) <b>Harrison McCulley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sally Teague</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Jeanne E. McCulley/ Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1189 Leeds Road, Elkton, Maryland 21921</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cherry Hill Methodist Cemetery</b>		Date <b>February 4, 1999</b>		20c. Location - City or Town, State <b>Cherry Hill, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921</b>				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <b>COPD</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>73yrs</b>		
		b. <b>CAD</b> Due to (or as a consequence of):				<b>1yr</b>		
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HTN</b> <b>CVD</b>								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  <b>MD</b>				29c. License number <b>D44716</b>		29d. Date signed (Month, Day, Year) <b>February 1, 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Jose Ma 111 W. High st, Elkton MD. 21921</b>								
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04775

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Josephine Beatrice Simms Miller</b>				2. Date of Death Month Day Year <b>January 31, 1999</b>		3. Time of Death <b>6:00 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Residence: 1005 Marcy Avenue, Apt. 201</b>				4b. City, Town, or Location of Death <b>Oxon Hill</b>		4c. County of Death <b>Prince Georges</b>	
Funeral Director	5. Social Security Number <b>577-84-2039</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>64</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 11, 1934</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Oxon Hill</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>1005 Marcy Avenue, Apt. 201</b>		10f. Zip Code <b>20745</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Domestic</b>			
	17. Father's Name (First, Middle, Last) <b>George Francis Simms</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Estelle Margaret Brown</b>			
	19a. Informant's Name/Relationship (Type, Print) (Daughter) <b>Lorraine Victoria Randolph</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3906 Ellis Street, Capitol Heights, Maryland 20743</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cemetery-Cheltenham</b>		20c. Date <b>Feb. 10, 1999</b>		20d. Location - City or Town, State <b>Cheltenham, Maryland</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Robert G. Mason Funeral Home, Inc. 1661 Good Hope Road, S.E.; Washington, D.C. 20020</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Esophageal Cancer.</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>D51638</b>		29d. Date signed (Month, Day, Year) <b>February 2, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR REBA MUKERJEE 5100 Auth Road, Suitland, Maryland 20746</b>								
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>				32. Registrar's Signature 				

672083-

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 04776

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Andy McCluney

2. Date of Death  
Month Day Year  
February 1, 19993. Time of Death  
7:30 AM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges'

Funeral  
Director

5. Social Security Number

240-58-5824

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

September 3, 1938

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

Maryland Prince Georges'

District Heights

10e. Street and Number

2507 Senator Avenue

10f. Zip Code

20747

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Recycling Company

17. Father's Name (First, Middle, Last)

Samuel McCluney

18. Mother's Name (First, Middle, Maiden Surname)

Pinkie Brown

19a. Informant's Name/Relationship (Type, Print)

Sandra A. McCluney - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2507 Senator Avenue, District Heights, Maryland 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

2-6-99

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service licensee

Lisa S. Johnson

22. Name and Address of Facility

Fort Lincoln Funeral Home

3401 Bladensburg Rd., Brentwood, Maryland 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Squamous Cell Lung Cancer, Stage IV

Due to (or as a consequence of):

c. COPD

Due to (or as a consequence of):

d. Post obstructive pneumonia

Approximate Interval Between Onset and Death

3-2 days

1-2 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Zafar Ansari, MD

29c. License number

D0053219

29d. Date signed (Month, Day, Year)

2/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zafar Ansari, MD. 8926 Woodward Rd, #101 Clinton, MD 20735

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

Zafar Ansari

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

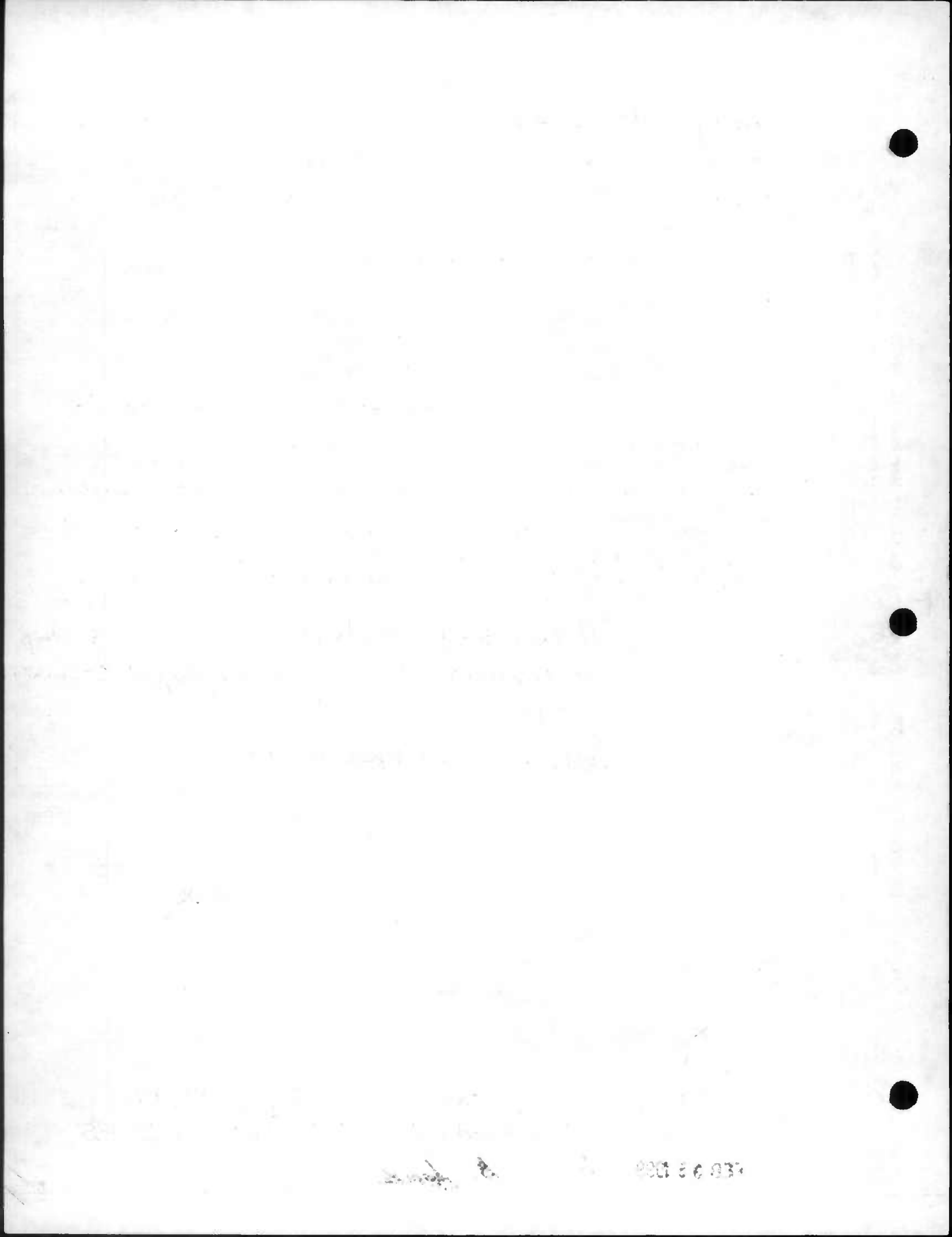
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



*[Handwritten signature/initials]*

200 26 93



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04777

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mabel Elizabeth Mitchell

2. Date of Death

Month Day Year  
Jan 31 1999

3. Time of Death

08:37 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-18-0156

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
January 1, 1909

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

900 G Street, N.E. #424

10f. Zip Code

20002

10g. Citizen of What Country?

United States America

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laundry Worker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John Henry King

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Stevenson

19a. Informant's Name/Relationship (Type, Print)

Mark Roy - Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

900 G Street, N.E. #424; Washington, DC 20002

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Hills Cemetery

Date

2/6/99

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

Glenda M. Freeman

22. Name and Address of Facility

Robert C. Freeman Funeral Services, Inc.  
1353 H Street, N.E.; Washington, DC 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Septic Shock

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Atrial Fibrillation, gastrointestinal bleeding, dementia, Stroke

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael F. M.D.

29c. License number

00052255

29d. Date signed (Month, Day, Year)

Jan 31 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muhammad Eliaz 8609 2nd Ave #404 B Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

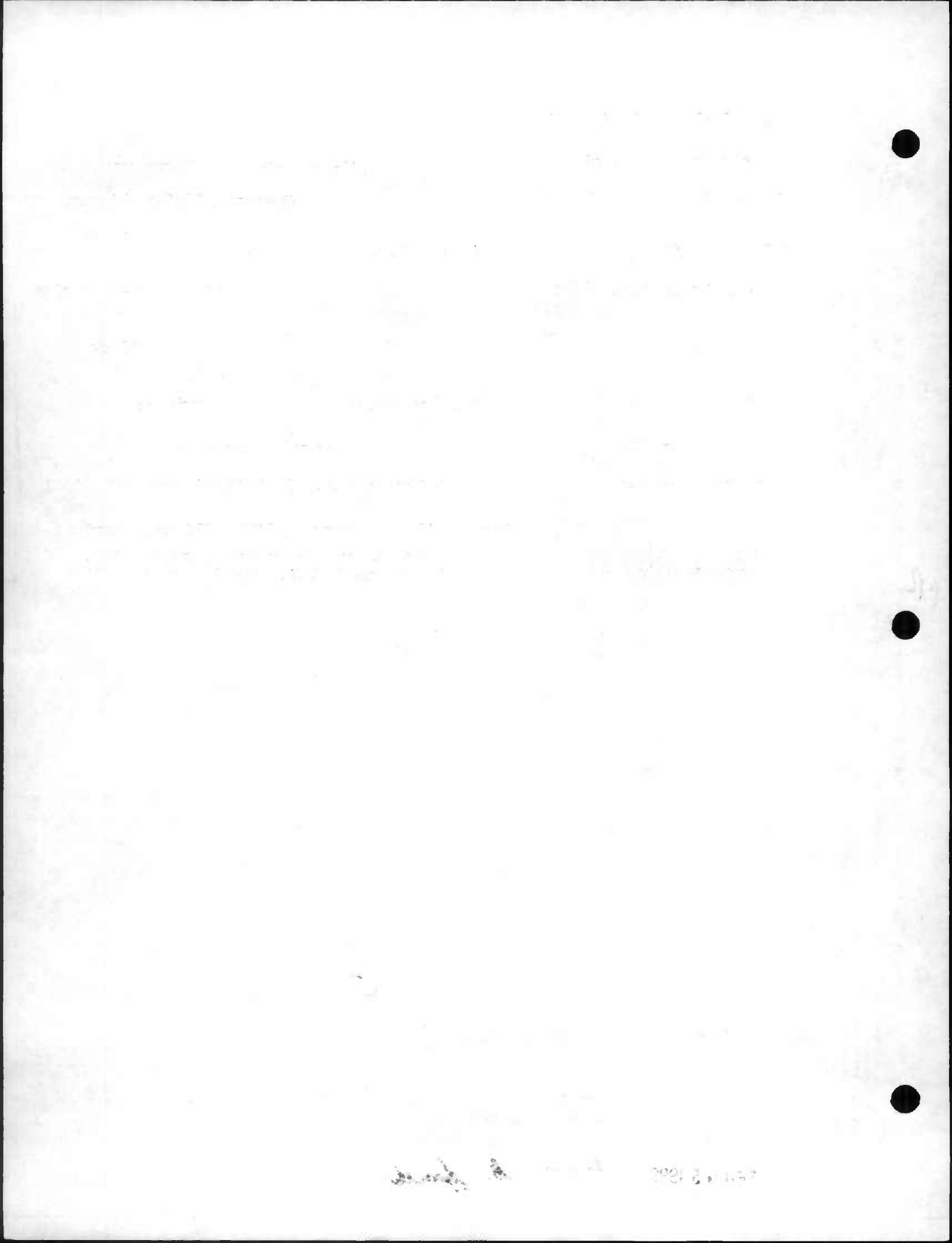
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04778

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ezra Maryamov

2. Date of Death

January 31, 1999

3. Time of Death

12:20 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

The Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

220-92-1315

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 4, 1908

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5910 Greentree Road

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Journalist

16b. Kind of Business/Industry

Documentary

17. Father's Name (First, Middle, Last)

Moshe Maryamov

18. Mother's Name (First, Middle, Maiden Summa)

Miriam (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Frieda I. Maryamov/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5910 Greentree Road, Bethesda, Maryland 20817

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mount Lebanon Cemetery

Date

Feb.

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Takoma Funeral Home

254 Carroll Street, NW, Washington, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

CEREBRAL THROMBOSIS

Approximate  
Interval Between  
Onset and Death

2 DAYS

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ESSENTIAL HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicida ☐ Homicida28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D15054

29d. Date signed (Month, Day, Year)

JANUARY 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. D. PATEL, M.D. 6121 MONTROSE RD, Rockville, MD 20852

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

202 : 8634

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04779

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph H. Mcleod				2. Date of Death Month Day Year Jan 27 1999		3. Time of Death 01:22PM	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-14-6944		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 2, 1912	
	9. Birthplace (State or Foreign Country) SOUTH CAROLINA		10a. State		10b. County		10c. City, Town or Location WASHINGTON, D.C.	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 1330 SOMERSET PLACE N.W.		10f. Zip Code 20011	
	10g. Citizen of What Country? UNITED STATES				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1945 to 1947	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BARBER				16b. Kind of Business/Industry SELF EMPLOYED		17. Father's Name (First, Middle, Last) JAMES H. McLEOD	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) CARRIE BROOME				19a. Informant's Name/Relationship (Type, Print) DOLORES FAYE BURKE (NIECE)			
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13409 COACHLAMP LANE, SILVER SPRING MARYLAND 20906				20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) FORT LINCOLN CEMETERY				20c. Location - City or Town, State 2-4-99 BRENTWOOD, MARYLAND		21. Signature of Funeral Service Licensee Ramon Dutens MOO907	
	22. Name and Address of Facility FORT LINCOLN FUNERAL HOME INC 3401 BLADENSBURG RD, BRENTWOOD MARYLAND 20722				23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ARRHYTHMIA Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. CHRONIC RENAL FAILURE Due to (or as a consequence of): d.			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier T. J. Anthony			
To Be Completed by Physician/Medical Examiner	29c. License number D 50300				29d. Date signed (Month, Day, Year) January 29, 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas J Anthony MD 9801 Georgia Ave Silver Spring Md 20902				31. Date filed (Month, Day, Year) FEB 0 1 1999			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature B. Jones				33. State Registrar FEB 0 1 1999			

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04780

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Melanie M. Mosby				2. Date of Death Month Day Year January 29 1999		3. Time of Death 1:49AM		
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 578-15-0077		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 18 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 25 1980	9. Birthplace (State or Foreign Country) Wash., D.C.	
	Usual Residence of Decedent				10c. City, Town or Location Bowie		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. State Maryland		10b. County Prince George's		10f. Zip Code 20720		10g. Citizen of What Country? United States			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry School			
17. Father's Name (First, Middle, Last) Horace Mosby				18. Mother's Name (First, Middle, Maiden Surname) Jean Speed					
19a. Informant's Name/Relationship (Type, Print) Jean Mosby - Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7003 Quisinberry Way; Bowie, MD 20720					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. Location - City or Town, State Wash., D.C.			
21. Signature of Funeral Service Licensee John T. Stewart III				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) motor vehicle Accident Due to (or as a consequence of): Subarachnoid Hemorrhage Cerebral edema Severe Head Injury				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 01-28-99		28b. Time of Injury 1925M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred OCCUPANT OF TRUCK VS TRUCK COLLISION	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET				28f. Location (Street and Number or Rural Route Number, City or Town, State) BOWIE, MARYLAND HILLMEADE & OLD CHAPEL ROAD					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number D45967		29d. Date signed (Month, Day, Year) 1-29-99			
29b. Signature and title of certifier Harold K. Miller									
30. Name and address of person who completed cause of death (from 23e) (Type, Print) Prince Georges Hospital Cheverly, MD									
31. Date filed (Month, Day, Year) FEB 02 1999				32. Registrar's Signature [Signature]					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

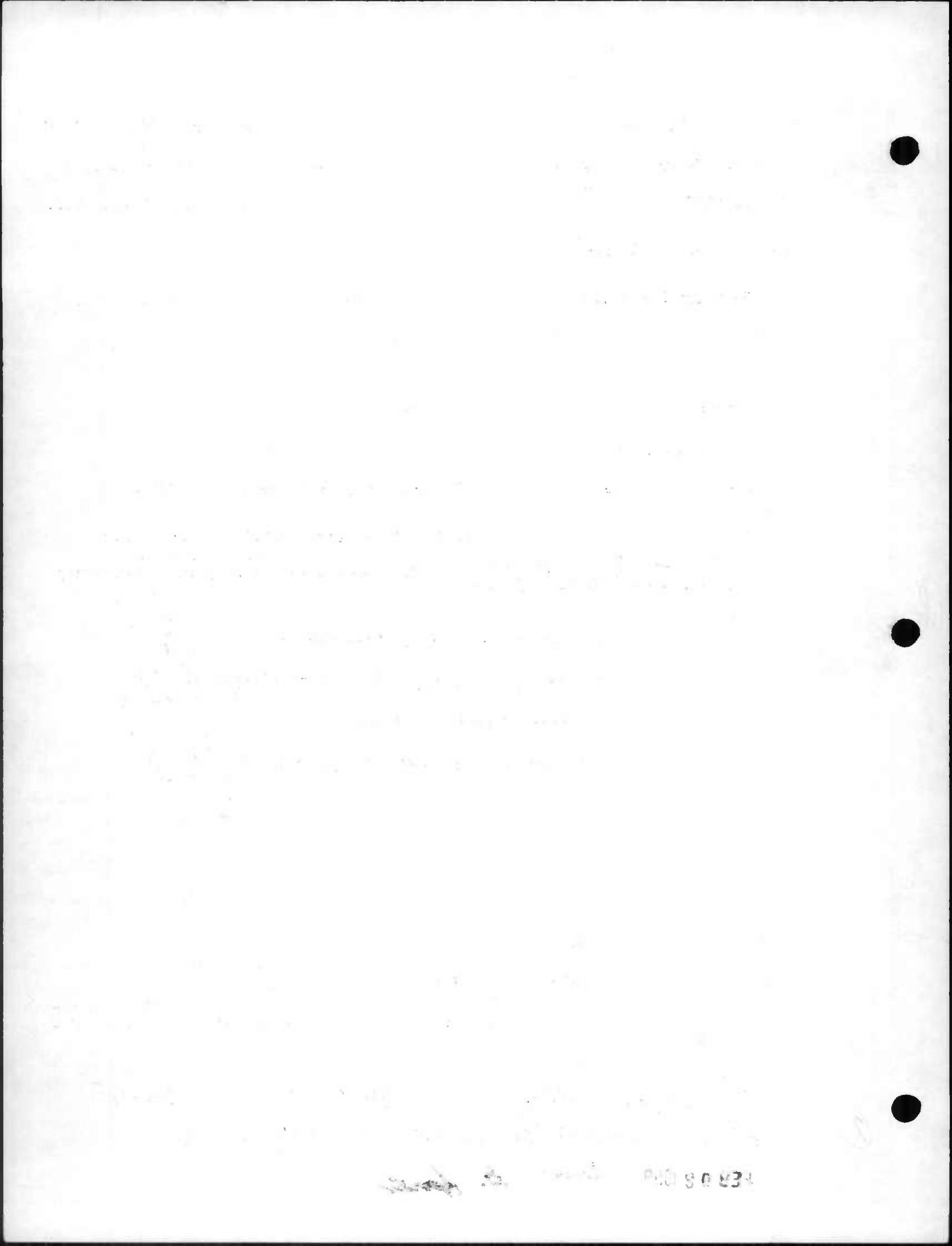
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04781

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Faison Morrissey

2. Date of Death

February 4, 1999

3. Time of Death

1:00 AM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

243-26-9879

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 8, 1919

9. Birthplace (State or Foreign Country)

Turkey, N.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6839 Standish Drive

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th Grade

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nurses Aid

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

James Faison

18. Mother's Name (First, Middle, Maiden Surname)

Donnie S. Faison

19a. Informant's Name/Relationship (Type, Print)

Agnes M. Potts/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2740 Lorrington Dr., Apt. #302, District Heights, MD 20742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hillcrest Cemetery

Date

Feb. 9,

1999

20c. Location - City or Town, State

Clinton, N.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Latney's Funeral Home

3831 Georgia Ave., N.W., Wash., D.C. 20011

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Aspiration

Approximate Interval Between Onset and Death

10 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Asphyxia

10 hrs

Encephalopathy

24 hrs

Respiratory failure

3 wks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sick Sinus Syndrome

Chronic obstructive lung

disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

234860

29d. Date signed (Month, Day, Year)

2/4/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

OLEG SHAPAK, 9470 ANNAPOLIS ROAD #302, LANHAM, MD 20706

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

State Registrar

MORRISSEY, Helen Faison

Baltimore, Maryland 21215-0020

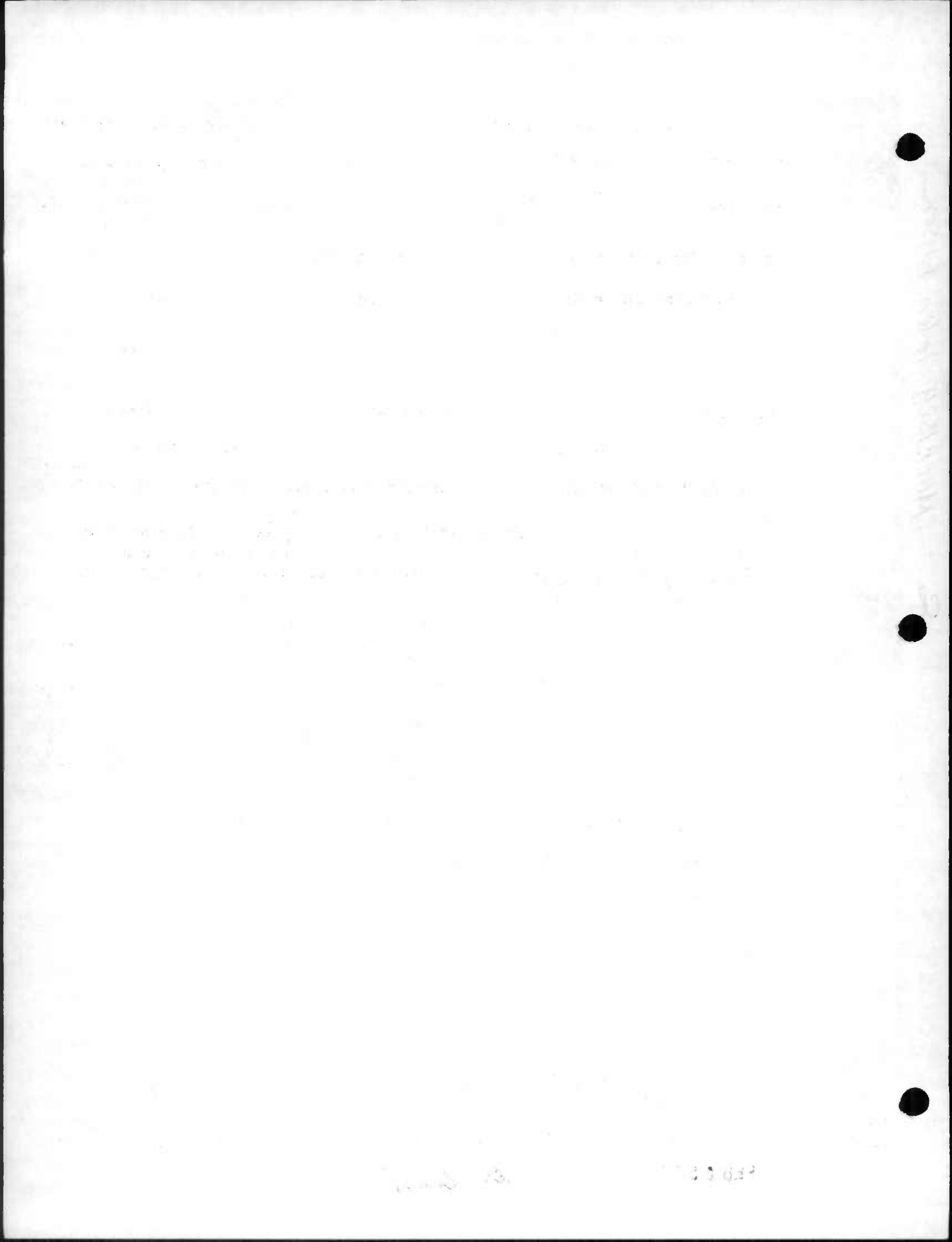
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04782

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARTIN FRANCIS MINER

2. Date of Death

January 29, 1999

3. Time of Death

2:12 PM

4a. Facility Name (If not institution, give street and number)

Naval Institute

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

132-34-2686

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 18, 1943

9. Birthplace (State or Foreign Country)

Bronx, New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1713 Grandin Avenue

10f. Zip Code

20851

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 yrs.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Automotive Finance Manager

16b. Kind of Business/Industry

Galaxx Automotive

17. Father's Name (First, Middle, Last)

Albert Minor

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Richards

19a. Informant's Name/Relationship (Type, Print)

Vivian Minor - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1713 Grandin Ave. Rockville, MD 20851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Lebanon Cemetery

Date

1/31/99

20c. Location - City or Town, State

Adelphi, Md.

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th Street N.W. Washington, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Brain death (Anoxic Encephalopathy)

Due to (or as a consequence of):

23 hrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiac Arrest - v-fib

Due to (or as a consequence of):

1/23/99

c. Hemolysis - severe

Due to (or as a consequence of):

1/23/99

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/P Bone marrow Transplant

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. P. Marshall M.D.

29c. License number

MD 30661

29d. Date signed (Month, Day, Year)

February 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK GLADWIN, M.D.

9000 ROCKVILLE PIKE, BETHESDA, MD 20892

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

J. P. Marshall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

8

State  
Registrar

097-6835

Amended # 31  
Allegany County mcv  
2/5/99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04783

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Sondra Lee Moore</b>		2. Date of Death Month Day Year <b>Feb. 1, 1999</b>		3. Time of Death <b>5:15 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>5213 57th Ave.</b>		4b. City, Town, or Location of Death <b>Riverdale</b>		4c. County of Death <b>Prince Georges</b>	
5. Social Security Number <b>218-38-0368</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Feb. 18, 1937</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
10e. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Riverdale</b>	
10f. Zip Code <b>20737</b>		10g. Citizen of What Country? <b>USA</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>	
17. Father's Name (First, Middle, Last) <b>Melvin Rice</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Lee Allamong</b>		19. Informant's Name/Relationship (Type, Print) <b>Richard E. Moore, Sr./Husband</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cemetery</b>		20c. Location - City or Town, State <b>Cumberland, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Ernst A. Riby, Jr.</b>		22. Name and Address of Facility <b>Leasure-Stein Funeral Home 230 Baltimore Ave. Cumberland, Md. 21502</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cervical Cancer</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>14 mo</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>MA # 80419</b>	
29d. Date signed (Month, Day, Year) <b>2.4.99</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Stacy J. [Signature] 9600 GEORGIA AVE WASHINGTON DC</b>			
31. Date filed (Month, Day, Year) <b>4 FEB 9 1999</b>		32. Registrar's Signature <b>[Signature]</b> <b>20967</b>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #26, Hospital in-patient, 2/10/99 Certificate of Death

Reg. No.

99 04784

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patrick William McHale</b>				2. Date of Death Month Day Year <b>FEBRUARY 7, 1999</b>		3. Time of Death <b>0232 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>PRINCE GEORGES HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>CHEVERLY</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>218 04 1493</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>31</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 13, 1968</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10. Usual Residence of Decedent		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
10a. State <b>MD</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Greenbelt</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>52 A Crescent Road</b>				10f. Zip Code <b>20770</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>landscaper - proprietor</b>		16b. Kind of Business/Industry <b>landscaping</b>		
17. Father's Name (First, Middle, Last) <b>Robert Richard McHale</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Brenda Estelle Leeka</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Robert R. McHale/father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4016 73rd Terrace East, Sarasota, FL 34243</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>2-9-99</b>		20c. Location - City or Town, State <b>Alexandria, VA</b>		
21. Signature of Funeral Service Licensee <i>Charles F. Bell</i>				22. Name and Address of Facility <b>Rausch Funeral Home, Owings, MD 20736</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Multiple Injuries</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>2/2/99</b>		28b. Time of Injury <b>2:26 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred <b>Driver of motor vehicle collides with bus</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Roadway</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Backtrack Road, Bowie, Md.</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>J. Pestaner, M.D.</i>				29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 7, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>FEB 10 1999</b>				32. Registrar's Signature <i>B. Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04785

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BESSIE

JONES-MCDANIEL

2. Date of Death

FEBRUARY 5, 1999

3. Time of Death

0415

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

215 44 8285

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 25, 1910

9. Birthplace (State or Foreign Country)

Lothian, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Owings

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

139 Thomas Road

10f. Zip Code

20736

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

keypunch operator

16b. Kind of Business/Industry

federal government

17. Father's Name (First, Middle, Last)

Wyville

18. Mother's Name (First, Middle, Maiden Surname)

Brady

Emma

Taylor

19a. Informant's Name/Relationship (Type, Print)

James D. Jones, Sr. son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 82, Owings, MD 20736

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Harmony Cemetery

Date

2-8-99

20c. Location - City or Town, State

Owings, MD

21. Signature of Funeral Service Licensee

William R. Jones

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS

Due to (or as a consequence of):

b. CARDIO RESPIRATORY FAILURE

Due to (or as a consequence of):

c. CLOSTRIDIUM DIFFICILE COLITIS

Due to (or as a consequence of):

d. UROSEPTIS

Approximate Interval Between Onset and Death

5 days

2 days

3 days

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Pranay R. Patel

29c. License number

D50249

29d. Date signed (Month, Day, Year)

2/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Pranay R. Patel, M.D. Prince Frederick, Maryland 20678

31. Date filed (Month, Day, Year)

FEB 08 1999

32. Registrar's Signature

Jennifer A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04786

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>John Francis McGinley</u>			2. Date of Death Month <u>February</u> Day <u>1</u> Year <u>1999</u>		3. Time of Death <u>0635</u>														
	4e. Facility Name (If not institution, give street and number) <u>Shady Grove Adventist Hospital</u>			4b. City, Town, or Location of Death <u>Rockville MD</u>		4c. County of Death <u>Montgomery</u>														
Funeral Director	5. Social Security Number <u>579-50-4721</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>59</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Sept. 1, 1939</u>													
	9. Birthplace (State or Foreign Country) <u>Wash., D.C.</u>																			
Usual Residence of Decedent																				
10e. State <u>MD</u>		10b. County <u>Montgomery</u>		10c. City, Town or Location <u>Poolesville</u>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
10e. Street and Number <u>17622 Kohlhoos Rd.</u>				10f. Zip Code <u>20837</u>		10g. Citizen of What Country? <u>U.S.A.</u>														
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>1962-1965</u> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Government Worker</u>		16b. Kind of Business/Industry <u>U.S. Government</u>														
17. Father's Name (First, Middle, Last) <u>Leo Francis McGinley</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Allyn Selden</u>																
19e. Informant's Name/Relationship (Type, Print) <u>James McGinley/brother</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>17113 Butler Rd. Poolesville, MD 20837</u>																
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Monocacy Cemetery</u>		Date <u>2/4</u>		20c. Location - City or Town, State <u>Beallsville, MD</u>														
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Hilton Funeral Home</u> <u>Box 86 Barnesville, MD 20838</u>																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Respiratory Failure</u></td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <u>hours</u></td> </tr> <tr> <td>b. <u>Lung Cancer</u></td> <td>Due to (or as a consequence of):</td> <td><u>weeks</u></td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <u>Respiratory Failure</u>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <u>hours</u>	b. <u>Lung Cancer</u>	Due to (or as a consequence of):	<u>weeks</u>	c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)	a. <u>Respiratory Failure</u>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <u>hours</u>																	
	b. <u>Lung Cancer</u>	Due to (or as a consequence of):	<u>weeks</u>																	
	c.	Due to (or as a consequence of):																		
	d.	Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CORONARY Artery Disease</u>																				
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																				
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred																
28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier <u>Joseph A Ball MD</u>				29c. License number <u>D0053317</u>		29d. Date signed (Month, Day, Year) <u>February 1, 1999</u>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Joseph A Ball 16220 Frederick Road Suite 213 Gaithersburg MD 20877</u>																				
31. Date filed (Month, Day, Year) <u>FEB 02 1999</u>				32. Registrar's Signature <u>[Signature]</u>																

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04787

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Birtrand Penrose Miskell, Sr.

2. Date of Death  
Month Day Year  
February 1, 19993. Time of Death  
6:30 P.M.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Health Care Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

219-20-2852

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

October 23, 1925

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

703 Northside Drive

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Flagman and Conductor

16b. Kind of Business/Industry

B&amp;O Railroad

17. Father's Name (First, Middle, Last)

Fairfax M. Miskell

18. Mother's Name (First, Middle, Maiden Surname)

Genieve Maggie Stallings

19a. Informant's Name/Relationship (Type, Print)

Marian A. Miskell, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

703 Northside Drive Frederick, Maryland 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

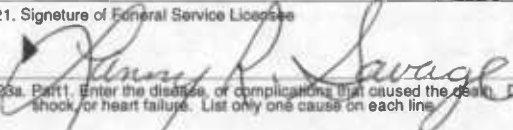
Date

2/6/99

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Stauffer Funeral Homes, P.A.

1621 Opossumtown Pike Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Underspread metastatic lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Asbestos Exposure

multiple C.V.A.s, Diabetic mellitus

D.V.T. (since 1990), HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

021944

29d. Date signed (Month, Day, Year)

2/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jane S. Grison MD, 300 W 9th St, Frederick, MD 21701

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04788

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS M. MCGHEE

2. Date of Death

Month

Day

Year

Feb 3 1999

3. Time of Death

7:20 AM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING MONTGOMERY

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

213-16-1153

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

MAY 13 1915

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND ANNE ARUNDEL

10b. County

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

701 GLENWOOD ST. APT. 409

10f. Zip Code

21401

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FARMER

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

ARTHUR MCGHEE

18. Mother's Name (First, Middle, Maiden Surname)

ROSE WHITE

19a. Informant's Name/Relationship (Type, Print)

FRED DOUGLAS (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3527 BANTRY WAY OLNEY, MD. 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LAKEMONT CEMETERY

Date

2/8/99

20c. Location - City or Town, State

DAVIDSONVILLE, MD.

21. Signature of Funeral Service Licensee

Larry G. Reese

22. Name and Address of Facility

WM. REESE &amp; SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

LUNG CANCER

Approximate Interval Between Onset and Death

5 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

UROSEPSIS, DEHYDRATION

RENAL INSUFFICIENCY, ANEMIA

GASTROINTESTINAL BLEEDING

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L. Chablan

29c. License number

D 42578

29d. Date signed (Month, Day, Year)

Feb 3 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gul Chablan, Md. 1119 Rockville PK #314 Rockville, Md. 20852

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

B. Spahr

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



State of Maryland / Department of Health and Mental Hygiene 99 04789  
Certificate of Death Reg. No.

### Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) Rita Frances Martinko

2. Date of Death Month February Day 1 Year 1999 3. Time of Death 6:50 pm

4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center

4b. City, Town, or Location of Death Annapolis

4c. County of Death Anne Arundel

5. Social Security Number 199-34-3183

6. Sex 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday) 53 Yrs.

8. Date of Birth (Month, Day, Year) April 7, 1945

9. Birthplace (State or Foreign Country) Pennsylvania

10a. State MD

10b. County Anne Arundel

10c. City, Town or Location Severna Park

10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 1117 Old County Road

10f. Zip Code 21146

10g. Citizen of What Country? USA

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senior Network Development Specialist

16b. Kind of Business/Industry Healthcare

17. Father's Name (First, Middle, Last) Francis Nicholl

18. Mother's Name (First, Middle, Maiden Surname) Rosanna Rossiter

19a. Informant's Name/Relationship (Type, Print) Harry J. Martinko / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1117 Old County Road, Severna Park, MD 21146

20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory

20c. Location - City or Town, State Baltimore, MD

21. Signature of Funeral Service Licensee [Signature]

22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. CVA

Due to (or as a consequence of): b. Brain metastasis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Melanoma

Due to (or as a consequence of): d.

Approximate Interval Between Onset and Death 3 days

1 mo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier [Signature] MD

29c. License number 1030118

29d. Date signed (Month, Day, Year) 2-2-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John Jackson MD, 2003 Medical Pkwy, Annapolis, MD 21401

31. Date filed (Month, Day, Year) FEB 03 1999

32. Registrar's Signature [Signature]

State Registrar

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04790

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gladys E. Nichols</b>				2. Date of Death Month <b>February</b> Day <b>1</b> Year <b>1999</b>		3. Time of Death <b>7:15 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>4321 Dover Drive</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>212-24-7498</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 8, 1925</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>4321 Dover Drive</b>		10f. Zip Code <b>21703</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>		16b. Kind of Business/Industry <b>State Hospital</b>		17. Father's Name (First, Middle, Last) <b>Leroy A. Arnold</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Irene S. Sibley</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Gail E. Nichols - Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4321 Dover Drive, Frederick, Maryland 21703</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Clarksburg Methodist Cem.</b>		20c. Location - City or Town, State <b>2/5/99 Clarksburg, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Olin L. Molesworth</i>		22. Name and Address of Facility <b>Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117</b>		23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>LUNG CANCER - SMALL CELL TYPE</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		23c. Date of Death (Month, Day, Year) <b>February 1, 1999</b>	
23d. Approximate Interval Between Onset and Death <b>6 WKS</b>		24a. Were an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Neil V. Waravdekar</i>		29c. License number <b>D47611</b>		29d. Date signed (Month, Day, Year) <b>February 1, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Neil V. Waravdekar, M.D. 1475 Taney Avenue, Frederick, Maryland 21702</b>	
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature <i>Benita S. Sparks</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04791

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EMILY NICOLE O'MEARA

2. Date of Death  
Month Day Year

January 11, 1999

3. Time of Death

10:52 PM

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

N/A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.

18

8. Date of Birth  
(Month, Day, Year)

January 11, 1999

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Bryantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6445 Sunnyside Drive

10f. Zip Code

20617

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
0

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Infant

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Stephen Paul O'Meara

18. Mother's Name (First, Middle, Maiden Surname)

Lynne Cameron O'Meara

19a. Informant's Name/Relationship (Type, Print)

Stephen P. O'Meara/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6445 Sunnyside Dr. Bryantown, MD 20617

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Memorial Gar.

Date

1/15/99 Waldorf, MD

21. Signature of Funeral Service Licensee

David C. Echols

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME P.A.

P.O. Box 567 LA PLATA, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intra Uterine Asphyxia  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

X ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes X ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☒ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Hammond J. Dugan, III MD

29c. License number

D-01912

29d. Date signed (Month, Day, Year)

2/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hammond J. Dugan, III MD MidAtlantic Emergency Physicians Group

575 Main St. Suite 253 Laurel, MD 20707

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 09 1999

32. Registrar's Signature

A. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04792

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DORIS O'BRIEN</b>				2. Date of Death Month <b>01</b> Day <b>30</b> Year <b>99</b>		3. Time of Death <b>12:20 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Saint Joseph's Nursing Home</b>				4b. City, Town, or Location of Death <b>Catonsville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>048-26-4459</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>August 6, 1908</b>		9. Birthplace (State or Foreign Country) <b>Connecticut</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Hyattsville</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>5215 42nd Place</b>				10f. Zip Code <b>20781</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Board of Education</b> <b>New Britain, CT</b>		
17. Father's Name (First, Middle, Last) <b>William W. Greene</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Donovan</b>				
19a. Informant's Name/Relationship (Type, Print) <b>William F. Tierney II - Nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5215 42nd Place, Hyattsville, Maryland 20781</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Saint Mary's Cemetery</b>		Date <b>02/05/99</b>		20c. Location - City or Town, State <b>New Britain, CT</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Gasch's Funeral Home, P.A.</b> <b>4739 Baltimore Avenue, Hyattsville, MD 20781</b>				
23a. Permit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Pulmonary Edema.</b> Due to (or as a consequence of): <b>b. Acute Myocardial Infarct.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Advanced - Organic Brain Syndrome (Alzheimer's)</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>208780</b>		29d. Date signed (Month, Day, Year) <b>Jan 30/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ALEJANDRO MESIA MD. 405 Frederick Rd. Balto 21228</b>								
31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

30

State  
Registrar

Handwritten text, possibly a signature or date, located in the middle section of the page.

Handwritten text, possibly a signature or date, located in the lower middle section of the page.

Handwritten text at the bottom of the page, including a date and a reference number.

40110833

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04793

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET R. PRICE

2. Date of Death

February 02 1999

3. Time of Death

1:41 AM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

231-28-8195

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

November 3, 1921

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Virginia

10b. County

Elizabeth City

10c. City, Town or Location

Hampton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

53 Mary Peake Boulevard

10f. Zip Code

23666

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Food Service

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Allen Roane

18. Mother's Name (First, Middle, Maiden Surname)

Lucinda Parker

19a. Informant's Name/Relationship (Type, Print)

Doris Price Summey/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9402 Caltor Lane, Ft. Washington, Maryland 20744

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hampton National Cemetery

Date

02/08  
1999

20c. Location - City or Town, State

Hampton, Virginia

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME  
7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)e. ASPIRATION PNEUMONIA  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 DAYS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY INSUFFICIENCY

SEVERE MALNUTRITION

CARCINOMA OF COLON

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicida  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Lucio S. Villa-Real

29c. License number

D15513

29d. Date signed (Month, Day, Year)

02/02/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUCIO S. VILLA-REAL, M.D. - #10 ST. PATRICK'S DRIVE, #502, WILDORE, MD 20603

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

Lucio S. Villa-Real

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04794

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles L. Pyle</b>				2. Date of Death Month <b>January</b> Day <b>31</b> Year <b>1999</b>		3. Time of Death <b>8:55 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Crofton Convalescent &amp; Rehab. Center</b>				4b. City, Town, or Location of Death <b>Crofton</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>577-16-2658</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 31 1921</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>New Carrollton</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>8305 Verona Dr.</b>		10f. Zip Code <b>20784</b>		10g. Citizen of What Country? <b>U.S.A</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self-Employed</b>		16b. Kind of Business/Industry <b>Charles L. Pyle Bakery Equipment</b>				
17. Father's Name (First, Middle, Last) <b>George L. Pyle</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nellie L. Owen</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Marjorie Sherman Pyle (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8305 Verona Dr. New Carrollton, MD 20784</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Md. Veterans Cemetery</b>		Date <b>2/5/99</b>		20c. Location - City or Town, State <b>Cheltenham, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rendon/Hale Funeral Home</b> <b>9013 Annapolis Rd. Lanham, MD 20706</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Stroke</b>  Due to (or as a consequence of): <b>Arteriosclerotic Cardiovascular Disease</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>Days</b> <b>Yrs</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D32261</b>		29d. Date signed (Month, Day, Year) <b>2-1-99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Richard J. Fellman 9000 Annapolis Rd, Lanham 20706</b>								
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



1. The first part of the report is a general  
description of the project. It includes the  
purpose, objectives, and scope of the work.  
2. The second part is a detailed description of  
the methodology used in the study. It includes  
the design, data collection, and analysis.  
3. The third part is a discussion of the results  
of the study. It includes the findings, conclusions,  
and recommendations.

4. The fourth part is a list of references.  
5. The fifth part is an appendix containing  
additional information related to the study.  
6. The sixth part is a glossary of terms.  
7. The seventh part is a list of figures and  
tables.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04795

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JUANITA PARKER

2. Date of Death

February 4, 1999

3. Time of Death

5:25 AM

4a. Facility Name (If not institution, give street and number)

Heartland Health Care

4b. City, Town, or Location of Death

Hyattsville, MD

4c. County of Death

Prince Georges Co.

Funeral  
Director

5. Social Security Number

173-12-9164

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 16, 1919

9. Birthplace (State or Foreign Country)

Jackson, GA

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5002 43rd Avenue

10f. Zip Code

20781

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Elevator Operator

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Clark Wright

18. Mother's Name (First, Middle, Maiden Surname)

Gussie Thurman Wright

19a. Informant's Name/Relationship (Type, Print)

Vanessa Parker Robinson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5002 43rd Ave., Hyattsville, MD 20781

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Restland Cemetery

Date

Feb. 9,

1999

20c. Location - City or Town, State

Pittsburg, PA

21. Signature of Funeral Service Licensee

*Stanley B. Barry*

22. Name and Address of Facility

Latney's Funeral Home  
3831 Georgia Ave., N.W., Wash., D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *ANTONIO SCENOTI Cardiovascular Disease years*

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Dementia with Delusions*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Paul A. De Vore*

29c. License number

*201852*

29d. Date signed (Month, Day, Year)

*FEBRUARY 5 1999*

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

*PAUL A. DE VORE MD 4203 Queensbury Rd Hyattsville MD 20781*

31. Date filed (Month, Day, Year)

*FEB 05 1999*

32. Registrar's Signature

*Paul A. De Vore*

State  
Registrar

Baltimore, Maryland 21215-0020

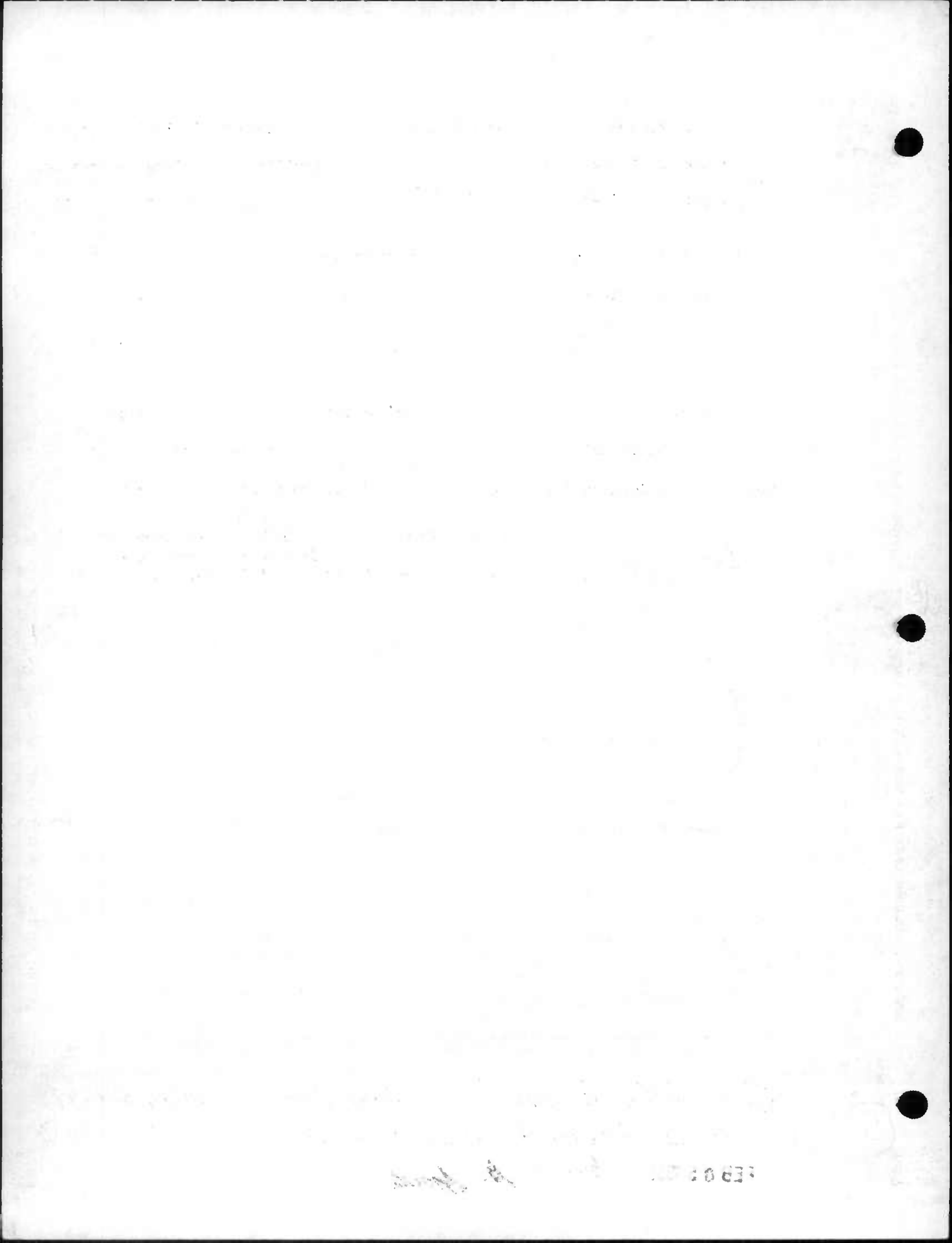
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04 796

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN FULTON PURCELL</b>			2. Date of Death Month <b>FEBRUARY</b> Day <b>4</b> Year <b>1999</b>		3. Time of Death <b>0600</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>219-05-3104</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN. 5, 1920</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent						
10a. State <b>MARYLAND</b>		10b. County <b>WICOMICO</b>		10c. City, Town or Location <b>SALISBURY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>435 VIRGINIA AVE.</b>			10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MAINTENANCE</b>		16b. Kind of Business/Industry <b>PETROLEUM INDUSTRY</b>		
17. Father's Name (First, Middle, Last) <b>JOHN FRANKLIN PURCELL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY ELIZABETH MARVEL</b>			
19a. Informant's Name/Relationship (Type, Print) <b>PATIENCE L. PURCELL - WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>435 VIRGINIA AVE. SALISBURY, MD 21801</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARSONS CEMETERY</b>		Date <b>2-8-99</b>		20c. Location - City or Town, State <b>SALISBURY, MARYLAND</b>	
21. Signature of Funeral Service Licensee <i>B. Keith Phym</i> <b>CFSP</b>				22. Name and Address of Facility <b>705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Ventricular Fibrillation → Cardiopalm Arrest</b> Due to (or as a consequence of): b. <b>Coronary artery Disease</b> Due to (or as a consequence of): c. <b>Atherosclerosis</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>15-45 min</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus, Hyperlipidemia, Fever / upper Resp Infection, Rx Bypass Surgery</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Magga</i> <b>218614</b>				29c. License number <b>218614</b>		29d. Date signed (Month, Day, Year) <b>2.4.99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Deepak Sagar, M.D. 547 E Riverside Dr Salisbury, MD</b>							
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>				32. Registrar's Signature <i>Benita B. Sparks</i>			

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04797

SS# 213-22-5551 2/3/99 1855

Baltimore, Maryland 21215-0020

Victoria Purnell

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Victoria Purnell</b>		2. Date of Death Month <b>2</b> Day <b>3</b> Year <b>99</b>		3. Time of Death <b>6:55 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Atlantic General Hospital</b>			4b. City, Town, or Location of Death <b>Berlin</b>		4c. County of Death <b>Worcester</b>
5. Social Security Number <b>213-22-5551</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <b>Feb 25, 1921</b>		9. Birthplace (State or Foreign Country) <b>MD</b>			
10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Berlin</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>11841 Sinepuxent Rd.</b>			10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>U.S.</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>		16b. Kind of Business/Industry <b>Private Families</b>	
17. Father's Name (First, Middle, Last) <b>Joseph Purnell</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Carrie T. Henry</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Clara Ayres /daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11841 Sinepuxent Rd., Berlin, MD 21811</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Calvary Pentecostal Cem</b>		20c. Location - City or Town, State <b>2/13/99 Bishopville, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Longestive heart failure</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					Approximate Interval Between Onset and Death <b>2 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>H44283</b>		29d. Date signed (Month, Day, Year) <b>2/3/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert D. Sparks 9733 Palmdale Drive Berlin, MD 21842</b>					
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature 			





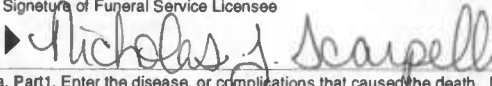
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04798

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>JUNE A. PRYOR</b>				2. Date of Death Month <b>Feb.</b> Day <b>1,</b> Year <b>1999</b>		3. Time of Death <b>12:20 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>220 HUMBIRD STREET</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
<b>Funeral Director</b>	5. Social Security Number <b>220-28-9991</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth Month <b>Mar</b> Day <b>31,</b> Year <b>1933</b>	
	9. Birthplace (State or Foreign Country) <b>WV</b>		10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>	
<b>To Be Completed by Funeral Director</b>	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>220 Humbird Street</b>		10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Ovey Shambaugh</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Olivia (Alderton)</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Clarence J. Pryor--husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>220 Humbird Street; Cumberland, MD 21502</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		Date <b>02/03</b>		20c. Location - City or Town, State <b>Flintstone, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Scarpelli Funeral Home, P.A. Cumberland, MD 21502</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>Congestive Heart Failure</b></p> <p style="text-align: center;">Due to (or as a consequence of):</p> <p>b. <b>Mitral Valve Disease</b></p> <p style="text-align: center;">Due to (or as a consequence of):</p> <p>c. <b>Cardiomyopathy</b></p> <p style="text-align: center;">Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 10%; text-align: center;"> <p>1 year</p> <p>25 yrs</p> <p>1 year</p> </div> </div>							
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p><b>COPD, Asthmatic Bronchitis</b></p> <p><b>Respiratory Failure</b></p> <p><b>C-Diff Colitis</b></p>							
<p>23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</p>								
<p>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>								
<p>25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p>								
<p>26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p>								
<p>27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</p>								
<p>28a. Date of Injury (Month, Day Year) <b>Feb 03 1999</b></p> <p>28b. Time of Injury <b>M</b></p> <p>28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p>								
<p>29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p>								
<p>29b. Signature and title of certifier </p> <p>29c. License number <b>D18769</b></p> <p>29d. Date signed (Month, Day, Year) <b>Feb. 3, 1999</b></p>								
<p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James M. Raver; Suite 400 Memorial Hospital; Cumberland, MD 21502</b></p>								
<p>31. Date filed (Month, Day, Year) <b>Feb 03 1999</b></p> <p>32. Registrar's Signature </p>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 1 Per AACo FilmG768 2-18-99 rja  
Amend. 1,26 1/15/99 SM AACo Health

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04799

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Elisabeth Pollard</i>				2. Date of Death Month Day Year Jan. 8 1999		3. Time of Death 12:00 PM	
	4a. Facility Name (If not institution, give street and number) 1918 Carrollton Road				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 220-56-0261	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 101 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 1, 1897	9. Birthplace (State or Foreign Country) W. Virginia	
	Usual Residence of Decedent							
10a. State Md.		10b. County Anne Arundel		10c. City, Town or Location Annapolis		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 1918 Carrollton Road				10f. Zip Code 21401		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry School		
17. Father's Name (First, Middle, Last) Rufus M. Cavendish				18. Mother's Name (First, Middle, Maiden Surname) Sallie Williams				
19a. Informant's Name/Relationship (Type, Print) Michael R. Davis / friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 Cape McKinsey Dr. Severna Park, Md. 21146				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. Location - City or Town, State 1-13-99 Baltimore, Md.				
21. Signature of Funeral Service Licensee <i>E. Brian Powell</i>				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Dementia</i> Due to (or as a consequence of): b. <i>Hypertension</i> Due to (or as a consequence of): c. <i>Peripheral Vascular Disease</i> Due to (or as a consequence of): d. <i>Cardiomegally</i>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>osteoarthritis</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Darryl Hill MD</i>				29c. License number 00053235		29d. Date signed (Month, Day, Year) 1/8/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Darryl Hill Anne Arundel Hosp. Annapolis, MD</i>								
31. Date filed (Month, Day, Year) JAN 15 1999		32. Registrar's Signature <i>P. Sparks</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04800

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Edgar Parker</b>				2. Date of Death Month <b>FEBRUARY</b> Day <b>6</b> , Year <b>1999</b>		3. Time of Death <b>8:50P</b>	
	4a. Facility Name (If not institution, give street and number) <b>VAMHCS, FORT HOWARD DIVISION</b>				4b. City, Town, or Location of Death <b>FORT HOWARD</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>214-07-8178</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 27, 1918</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>713 Peachblossom Avenue</b>				10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>US</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>11</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Hardware Store</b>		
17. Father's Name (First, Middle, Last) <b>Walter B. Parker</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Cleta Keene</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Eugenia P. Dunnock Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10070 Sharptown Road Mardela Springs, MD 21837</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dorchester Memorial Park</b>		Date <b>2/9/99</b>		20c. Location - City or Town, State <b>Cambridge, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>BACTERIAL SEPTICEMIA</b> Due to (or as a consequence of): <b>MULTI-INFARCT DEMENTIA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>BACTERIAL SEPTICEMIA</b> Due to (or as a consequence of): <b>MULTI-INFARCT DEMENTIA</b> Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>2 Weeks</b> <b>2 Weeks</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medicot examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signatures and title of certifier  M.D.						
		29c. License number <b>34359 (OH10)</b>		29d. Date signed (Month, Day, Year) <b>2-7-1999</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. JOHN LAH, MD--9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052</b>								
31. Date filed (Month, Day, Year) <b>FEB 8 1999</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

AKA: PARKER, JAMES E.

Baltimore, Maryland 21215-0020  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene 99 04801

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Leslie J. Pierre</b>						2. Date of Death Month Day Year <b>January 29, 1999</b>		3. Time of Death <b>8:45 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>188 Inverness Road</b>						4b. City, Town, or Location of Death <b>Severna Park</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>216-22-0575</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 17, 1911</b>		9. Birthplace (State or Foreign Country) <b>Minnesota</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severna Park</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>188 Inverness Road</b>				10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Civil Engineer</b>			16b. Kind of Business/Industry <b>Construction</b>			
17. Father's Name (First, Middle, Last) <b>John Pierre</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Welter</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Edith Pierre / wife</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>188 Inverness Road, Severna Park, MD 21146</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Cemetery</b>		Date <b>Feb 1 1999</b>		20c. Location - City or Town, State <b>Glen Burnie, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Aspiration pneumonia</b> Due to (or as a consequence of):  b. <b>Cerebrovascular Accidents</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>1 week</b> <b>several years</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinson's disease</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D30701</b>		29d. Date signed (Month, Day, Year) <b>1/29/99</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT SWITT EDEN, MD, 600 RIDGELY AVE, ANNAPOLIS, MD 21401</b>										
31. Date filed (Month, Day, Year) <b>FEB 03 1999</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04802

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ghulam Mohammad Qazi</b>				2. Date of Death Month <b>February</b> Day <b>3</b> Year <b>1999</b>		3. Time of Death <b>1:55 p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>21613 Liberty St., Apt. 707</b>				4b. City, Town, or Location of Death <b>Lexington Park</b>		4c. County of Death <b>St. Mary's</b>	
Funeral Director	5. Social Security Number <b>957 79 7214</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov 5, 1933</b>	9. Birthplace (State or Foreign Country) <b>Kashmir, India</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Lexington Park</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>21613 Liberty Street, Apt. 707</b>				10f. Zip Code <b>20653</b>		10g. Citizen of What Country? <b>India</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Indian</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>professor</b>			16b. Kind of Business/Industry <b>university</b>	
17. Father's Name (First, Middle, Last) <b>Mohammad Hussain Qazi</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Begum</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Sakina Zuhra wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as # 10 above</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Islamic Cemetery</b>		Data <b>2-4-99</b>		20c. Location - City or Town, State <b>Prince Frederick, MD</b>		
21. Signature of Funeral Service Licensee <b>William B. Grier</b>				22. Name and Address of Facility <b>Rausch Funeral Home, P.A., Owings, MD 20736</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Colon Cancer</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c. Sequenced disorder secondary to alone. Hypertension</b>								Approximate Interval Between Onset and Death <b>~ 8 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sequenced disorder secondary to alone. Hypertension</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28t. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>David M. Federle MD</b>		29c. License number <b>D39198</b>		29d. Date signed (Month, Day, Year) <b>2/4/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID M. FEDERLE MD, 24035 THREE NOTCH RD, HOLLYWOOD MD 20636</b>								
31. Date filed (Month, Day, Year) <b>FEB 08 1999</b>		32. Registrar's Signature <b>B. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04803

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rachel Beers Racine</b>				2. Date of Death Month <b>FEBRUARY</b> Day <b>6</b> Year <b>1999</b>				3. Time of Death <b>06:50 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>UNION HOSPITAL EMERGENCY DEPT</b>				4b. City, Town, or Location of Death <b>Elkton</b>				4c. County of Death <b>Cecil</b>			
Funeral Director	5. Social Security Number <b>220-05-1036</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>81</b> Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) <b>June 7, 1917</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>				10b. County <b>Cecil</b>			
To Be Completed by Funeral Director	10c. City, Town or Location <b>Childs</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>376 Star Route Road</b>			
	10f. Zip Code <b>21916</b>				10g. Citizen of What Country? <b>United States</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Postmaster</b>				16b. Kind of Business/Industry <b>United States Postal Service</b>			
	17. Father's Name (First, Middle, Last) <b>George Richard Beers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>May Campbell</b>				19a. Informant's Name/Relationship (Type, Print) <b>Allen Eugene Racine/ Son</b>			
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>382 Star Route Road, Childs, Maryland 21916</b>				20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Saint John's Methodist Cemetery</b>			
	20c. Location - City or Town, State <b>Lewisville, Pennsylvania</b>				21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921</b>			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ASCVD</b>				23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	23d. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CONGESTIVE HEART FAILURE</b>				23e. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE MYOCARDIAL INFARCTION</b>				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>				
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				
29c. License number <b>D31704</b>				29d. Date signed (Month, Day, Year) <b>February 6th 1999</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PATRICIA A. WEBER M.D. UNION HOSPITAL ED</b>				
31. Date filed (Month, Day, Year) <b>FEB 08 1999</b>				32. Registrar's Signature 				State Registrar				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#6 PER INFMNT. G778 12-16-99 J.A.

## Certificate of Death

Reg. No.

99 04804

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Rasheedah T. Rasheed

2. Date of Death

Month Day Year  
January 29, 1999

3. Time of Death

12:45 A.M.

4a. Facility Name (If not institution, give street and number)

Larkin-Chase Nursing Home

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

5. Social Security Number

578-54-8335

6. Sex

XXM 2XXF

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
January 7, 1902

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1XXYes 2XXNo

10e. Street and Number

6803 Irene Court

10f. Zip Code

20720

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1XXNever Married 2XXMarried

3XXWidowed 4XXDivorced

12. Was Decedent Ever in U.S.

Armed Forces?

1XXYes 2XXNo

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1XXYes 2XXNo Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

5th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nurses Aid

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John Brown

18. Mother's Name (First, Middle, Maiden Surname)

Jenny Bar

19a. Informant's Name/Relationship (Type, Print)

Mrs. Barbara J. Peterson (Grand-Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6803 Irene Court Bowie, Maryland 20720

20a. Method of Disposition

1XXBurial 2XXCremation 3XXRemoval from State

4XXDonation 5XXOther (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

National Harmony Memorial Park

Date

2/2/99

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rollins Funeral Home, Inc.

4339 Hunt Place, N.E. Washington, D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Metastatic Terminal Cancer of the Colon

Years

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1XXYes 2XXNo 3XXProbably 4XXUnknown

24a. Was an autopsy  
performed?

1XXYes 2XXNo

24b. Were autopsy findings  
available prior to  
completion of causa  
of death?

1XXYes 2XXNo

25. Was case referred to medical  
examiner?

1XXYes 2XXNo

26. Place of Death (Check only one)

Hospital:

1XXInpatient 2XXER/Outpatient 3XXDOA

Other:

4XXNursing Home 5XXResidence 6XXOther (Specify)

27. Manner of Death

1XXNatural 2XXAccident 3XXSuicide 4XXHomicide  
5XXPending investigation  
6XXCould not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1XXYes 2XXNo

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed causa of death (Item 23e) (Type, Print)

Rakesh Arora, M.D.

14300 Gallant Fox Lane Bowie, Maryland 20715

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

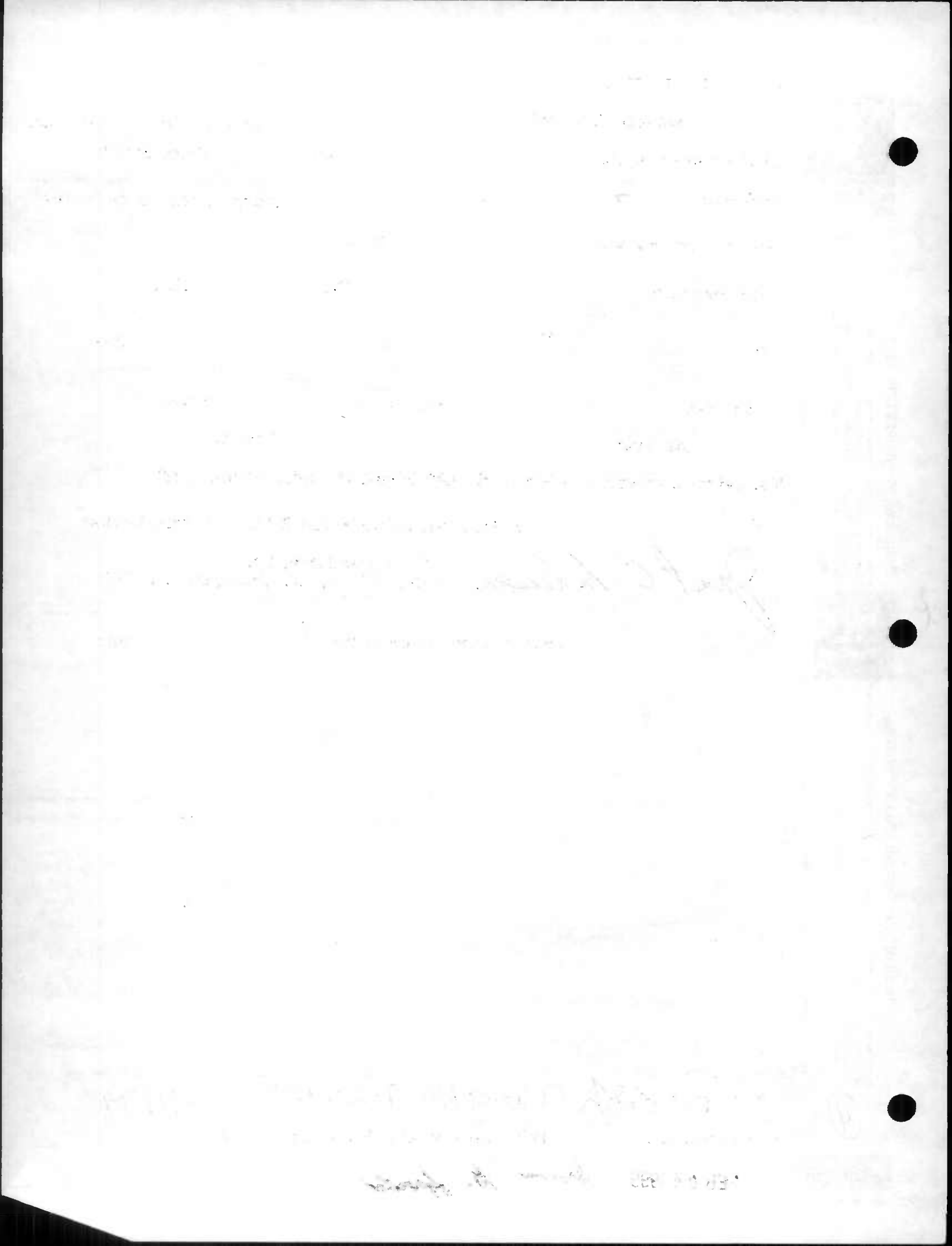
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(4)





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04805

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Minnie Cohen Rosenbloom

2. Date of Death

January 27, 1999

3. Time of Death

7:00 AM

4a. Facility Name (If not institution, give street and number)

14510 Homecrest Road, Apt. #208

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

579-05-4872

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 6, 1912

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

14510 Homecrest Road, Apt. #208

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Max Shock

18. Mother's Name (First, Middle, Maiden Surname)

Lena Stacliskay

19a. Informant's Name/Relationship (Type, Print)

Elaine Phyllis Pitler/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1500 Woodman Drive, Silver Spring, Maryland 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Elesavetgrad Cemetery

Date

Jan.

20c. Location - City or Town, State

29, 1999 Washington, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Takoma Funeral Home

254 Carroll Street, NW, Washington, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Arteriosclerotic heart disease*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D13548

29d. Date signed (Month, Day, Year)

1. 29. 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. SARIN 10801 LOCK WOOD DRIVE SUITE 280 SILVER SPRING MD 20906

31. Date filed (Month, Day, Year)

FEB 02 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

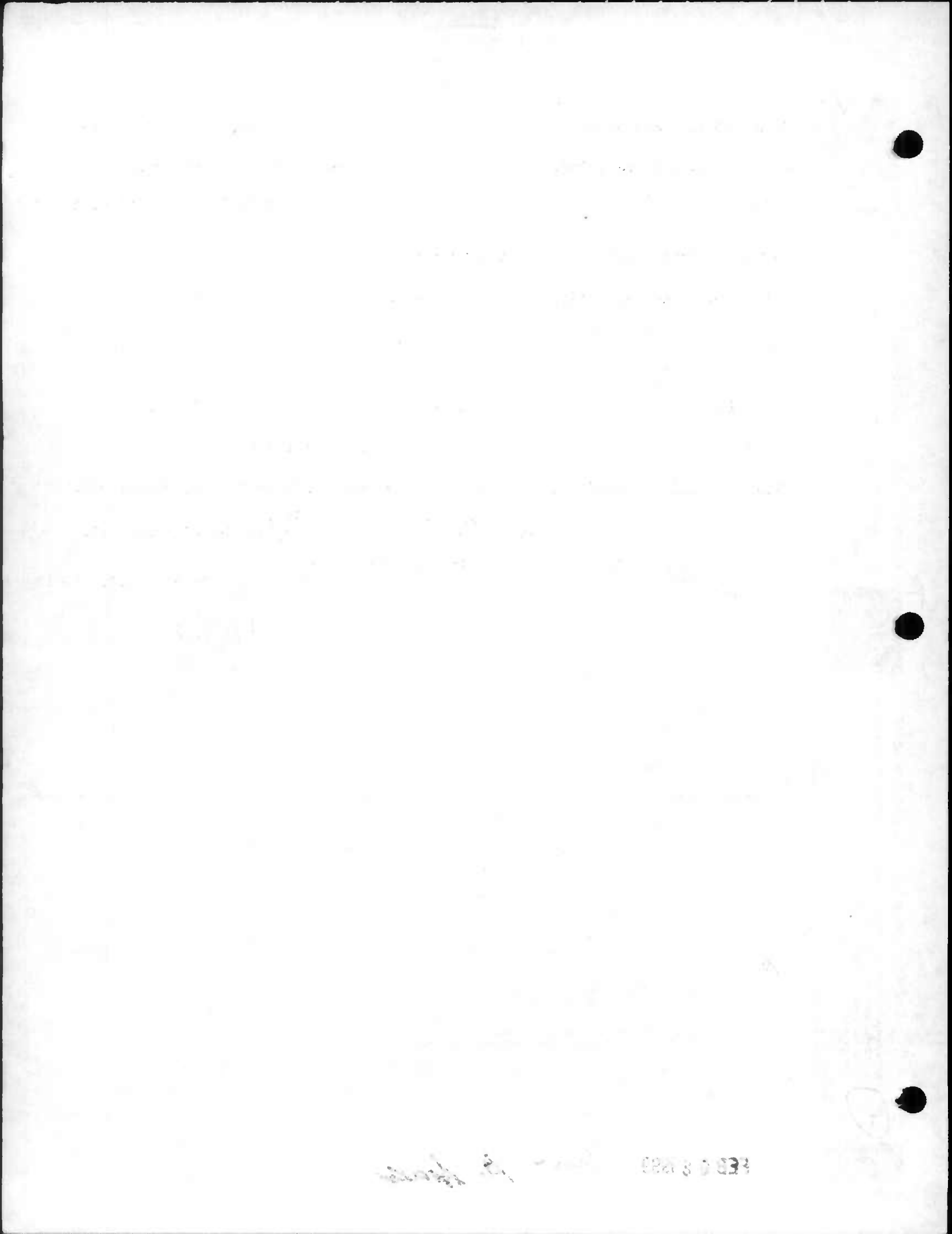
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

9 04806

Ratkowski

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LILLIAN M. RATKOWSKI</b>				2. Date of Death Month Day Year <b>JANUARY 26, 1999</b>				3. Time of Death <b>7:15 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>HEBREW HOME</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>				4c. County of Death <b>MONTGOMERY COUNTY</b>	
Funeral Director	5. Social Security Number <b>247-07-1979</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 13, 1914</b>		9. Birthplace (State or Foreign Country) <b>GEORGIA</b>	
	Usual Residence of Decedent									
10e. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>GAITHERSBURG</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>11920 RAVEN ROCK TERRACE</b>				10f. Zip Code <b>20878</b>				10g. Citizen of What Country? <b>UNITED STATES</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>				16b. Kind of Business/Industry <b>OWNED HOME</b>		
17. Father's Name (First, Middle, Last) <b>JOSEPH GUEST</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LILY FIELDS</b>						
19e. Informant's Name/Relationship (Type, Print) <b>SHIRLEY HOLLEY, DAUGHTER-IN-LAW</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11920 RAVEN ROCK TERRACE, GAITHERSBURG, MD 20878</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FORT LINCOLN CEMETERY</b>		Date <b>1/29/99</b>		20c. Location - City or Town, State <b>BRENTWOOD, MARYLAND</b>		
21. Signature of Funeral Service Licensee <i>David Butting</i>				22. Name and Address of Facility <b>FORT LINCOLN FUNERAL HOME</b> <b>3401 BLADENSBURG RD., BRENTWOOD, MD 20722</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. DYSPHAGIA</b> Due to (or as a consequence of): <b>b. METASTATIC CARCINOMA OF COLON</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Approximate Interval Between Onset and Death <b>1 MONTH</b> <b>MONTHS</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CEREBROVASCULAR ACCIDENT</b>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number <b>D 05885</b>				29d. Date signed (Month, Day, Year) <b>01/27/99</b>		
29b. Signature and title of certifier <i>Steven Lipson MD</i>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STEVEN LIPSON 6021 MONTROSE RD, ROCKVILLE</b>										
31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>				32. Registrar's Signature <i>Anna A. [unclear]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page]*



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM EDWARD ROBEY

2. Date of Death

Month Day Year  
FEBRUARY 6 1999

3. Time of Death

10:15 AM

4a. Facility Name (If not institution, give street and number)

420 WINNER STREET

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

218-70-2070

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC 25 1955

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

420 WINNER STREET

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CSX RAILROAD

16b. Kind of Business/Industry

MACHINIST HELPER

17. Father's Name (First, Middle, Last)

AUGUST VICTOR ROBEY

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY CHRISTINE WIDDOWS

19a. Informant's Name/Relationship (Type, Print)

EDWARD ROBEY BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1021 HARDING AVE CUMBERLAND MARYLAND 21502

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CUMBERLAND CREMATORY FEB 6 1999 CUMBERLAND MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME  
404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Unknown

b. Nicotine Abuse

Due to (or as a consequence of):

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alcohol Abuse Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Snow

29c. License number

D 09157

29d. Date signed (Month, Day, Year)

FEBRUARY 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR PAUL SNOW 124 WEST THIRD STREET CUMBERLAND MARYLAND 21502

31. Date filed (Month, Day, Year)

FEB 08 1999

32. Registrar's Signature

B. Snow

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

15/11/2003

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04808

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Juanita M. Richitt</b>				2. Date of Death Month Day Year <b>February 1, 1999</b>				3. Time of Death <b>10:20 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>3811 Outrigger Drive</b>				4b. City, Town, or Location of Death <b>Edgewater</b>				4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>579-60-3835</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 21, 1911</b>		9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Edgewater</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>3811 Outrigger Drive</b>				10f. Zip Code <b>21037</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Assistant</b>				16b. Kind of Business/Industry <b>Internal Revenue Service</b>			
17. Father's Name (First, Middle, Last) <b>(unknown)</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nora Henry</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Donald A. Richitt/ Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3811 Outrigger Drive Edgewater, Maryland 21037</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakemont Mem'l. Gardens</b>		20c. Location - City or Town, State <b>2-5-99 Davidsonville, MD</b>					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037</b>							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Stroke</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>aspirin pneumonia</b>  Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death <b>6 w</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Rheumatoid arthritis</b>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				28d. Describe how Injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner				29c. License number <b>D 21438</b>							
29b. Signature and title of certifier 				29d. Date signed (Month, Day, Year) <b>February 2, 1999</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL J. LAFORTE MD 6000 GAY AVE STE 1W ANNAPOLIS MD 21401</b>											
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louise Benner Rummel

2. Date of Death

Month Day Year  
Feb 1 99

3. Time of Death

4:15 pm

4a. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-46-5599

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar 20, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

709 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Conrad Benner

18. Mother's Name (First, Middle, Maiden Surname)

Olga Ernie

19a. Informant's Name/Relationship (Type, Print)

Carol Seitz / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

119 Round Bay Road, Severna Park, MD 21146

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cem.

Date

Feb 4 1999

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park F.H.  
495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart failure

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural  
☐ Accident  
☐ Suicide  
☐ Homicide

☐ Pending investigation  
☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* MD

29c. License number

D 51051

29d. Date signed (Month, Day, Year)

February 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andres Salazar 711 Maidenchoice Lane, Catonsville, MD, 21228

31. Date filed (Month, Day, Year)

FEB 03 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Name: Louise Rummel  
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04810

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Willard Grayson Simmons				2. Date of Death Month Day Year January 29, 1999		3. Time of Death 2:40 am	
	4a. Facility Name (If not institution, give street and number) Residence: 155 North Main Street				4b. City, Town, or Location of Death Port Deposit		4c. County of Death Cecil	
Funeral Director	5. Social Security Number 217-60-2765		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) May 30, 1954	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Cecil		10c. City, Town or Location Port Deposit	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 155 North Main Street		10f. Zip Code 21904	
	10g. Citizen of What Country? U.S.A.				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1971-72	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Twelve Years College (1-4 or 5+) ---	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shed Utility Worker				16b. Kind of Business/Industry Harrison-Walker Refractories North East, Maryland		17. Father's Name (First, Middle, Last) John W. Simmons	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Vida Elizabeth Shortridge				19a. Informant's Name/Relationship (Type, Print) Sheila D. Simmons (wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 155 North Main Street, Port Deposit, Maryland 21904	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Co., Inc.		20c. Location - City or Town, State West Chester, Pennsylvania		20d. Date 2/4/99	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Thomas M. Patterson Jr.</i>				22. Name and Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0188			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <u>CARCINOMA OF LUNG WITH BRAIN METS</u> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____				Approximate Interval Between Onset and Death 19 months			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of Certifier <i>Suresh Dhanjani MD</i>		29c. License number D 45344		29d. Date signed (Month, Day, Year) 1/29/99	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SURESH DHANJANI MD, 20 CRAIGTOWN RD, PERRYVILLE, MD 21903							
	31. Date filed (Month, Day, Year) FEB 03 1999				32. Registrar's Signature <i>Denise B. Sparks</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04811

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Elizabeth Schubmehl				2. Date of Death Month Day Year February 4, 1999				3. Time of Death 5:50pm			
	4a. Facility Name (If not institution, give street and number) 2789 Moran Drive				4b. City, Town, or Location of Death Waldorf				4c. County of Death Charles			
Funeral Director	5. Social Security Number 226-66-8756		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) July 4, 1911		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Charles		10c. City, Town or Location Waldorf				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 2789 Moran Drive				10f. Zip Code 20601				10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Charles Jenkins Edelen, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Attawa Middleton							
	19a. Informant's Name/Relationship (Type, Print) John T. Sunstone, Jr.-Cousin				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2789 Moran Drive, Waldorf, MD 20601							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Columbia Gardens Cem/.		Date 2-8-99		20c. Location - City or Town, State Alexandria, VA			
	21. Signature of Funeral Service Licensee Mark G. Brohawn M00053				22. Name and Address of Facility Huntt Funeral Home P. O. Box 156, Waldorf, MD 20601							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CANCER OF COLON Due to (or as a consequence of):  b. LIVER METS Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 2 mo	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier Keiser M. Rom				29c. License number 028352				29d. Date signed (Month, Day, Year) 2/8/99				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PO Box 1703, La Plata Md. 20646												
31. Date filed (Month, Day, Year) FEB 09 1999				32. Registrar's Signature B. Sparks								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Brian Scott Stokely</b>				2. Date of Death Month <b>FEB.</b> Day <b>5</b> , Year <b>1999</b>		3. Time of Death <b>0231 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>ACCOKEEK &amp; GARDNER ROAD</b>				4b. City, Town, or Location of Death <b>ACCOKEEK</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>216-82-7867</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>23</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 20, 1975</b>	
	9. Birthplace (State or Foreign Country) <b>Washington DC</b>		10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>La Plata</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>9755 Elm Lane</b>		10f. Zip Code <b>20646</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Voltage Technician</b>		16b. Kind of Business/Industry <b>Electrical</b>				
17. Father's Name (First, Middle, Last) <b>Chesley Bernard Stokely, Jr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Lourdes Curry Stokely</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mary C. Stokely/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9755 Elm Lane La Plata, MD 20646</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 2/6</b>		20c. Location - City or Town, State <b>Alexandria, VA</b>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Arehart-Echols Funeral Home, P.A. P.O. Box 567 La Plata, MD 20646</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <u>Heart Disease</u></b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>2 5 99</b>		28b. Time of Injury <b>0231 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred <b>WITH OXBOAT PASSAGE IN CANAL IMPACT</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>ROADWAY</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>ACCOKEEK &amp; GARDNER PRINCE GEORGES</b>		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>FEB. 5, 1999</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Wayne D. Sparks 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>FEB 09 1999</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04813

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Beatrice Stoltz</i>				2. Date of Death Month: <i>2</i> Day: <i>3</i> Year: <i>99</i>		3. Time of Death <i>10:05 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Althea Woodland Nursing Home</i>				4b. City, Town, or Location of Death <i>Silver Spring</i>		4c. County of Death <i>Montgomery</i>	
Funeral Director	5. Social Security Number <i>218-30-2607</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>95</i> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) <i>1-21-04</i>	9. Birthplace (State or Foreign Country) <i>Washington, DC</i>
	Usual Residence of Decedent				10c. City, Town or Location <i>Silver Spring</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State <i>Maryland</i>		10b. County <i>Montgomery</i>		10e. Street and Number <i>1000 Daleview Drive</i>		10f. Zip Code <i>20901</i>		10g. Citizen of What Country? <i>U.S.A.</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <i>12</i> Collage (1-4 or 5+):				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>		
17. Father's Name (First, Middle, Last) <i>Charles Albert Brewton</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Emily Shaffer</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Robert B. Stoltz - Son</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7119 Garland Avenue, Takoma Park, Maryland 20912</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metroplitan Crematory</i>		20c. Location - City or Town, State <i>02/05/99 Alexandria, Virginia</i>		
21. Signature of Funeral Service Licensee <i>Henry J. [Signature]</i>				22. Name and Address of Facility <i>Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Acute Myocardial infarction</i> Due to (or as a consequence of): <i>b. Congestive heart failure</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								Approximate Interval Between Onset and Death  <i>6 months</i>
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Smith S. Ho</i>		29c. License number <i>D21900</i>		29d. Date signed (Month, Day, Year) <i>February 3, 1999</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>SMITH S. HO 7610 Carroll Ave. #280 Takoma Park Md. 20912</i>								
31. Date filed (Month, Day, Year) <i>FEB 05 1999</i>				32. Registrar's Signature <i>[Signature]</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04814

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth M. Stanley

2. Date of Death

January 28, 1999

3. Time of Death

10:44 AM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

237-22-0165

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 18, 1913

9. Birthplace (State or Foreign Country)

Pink Hill, N.C.

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1435 Newton Street N.W.

10f. Zip Code

20010

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

George Stanley

18. Mother's Name (First, Middle, Maiden Surname)

Marenda Farrior

19a. Informant's Name/Relationship (Type, Print)

Mildred Jones / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1014 Cadillac Dr. Daytona Beach, Florida 32117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Washington National

Date

2/2/99

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

*Keith G. Jones* 1/10/99

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Md. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Alzheimer's Disease*

Due to (or as a consequence of):

10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Dementia - Organic Brain Syndrome* 10 years.

Due to (or as a consequence of):

c. *Compressive fractures of spine* 15 years.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*4/4/99 Jan 28 1999*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicidal 4 ☐ Homicidal

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*M. Wajed Khan*

29c. License number

D32817

29d. Date signed (Month, Day, Year)

January 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Wajed Khan, MD 12016 Georgia Ave, Wheaton MD 20702

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

*[Signature]*State  
Registrar

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04815

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LINDA H. SCOTT				2. Date of Death Month: 01 Day: 31 Year: 99		3. Time of Death 9:30 AM	
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 251-88-2265		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) Jan 16, 1949	
	9. Birthplace (State or Foreign Country) Charleston, SC		10a. State MD		10b. County Prince George's		10c. City, Town or Location Temple Hills	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 3708 Portal Avenue				10f. Zip Code 20748		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker		16b. Kind of Business/Industry DC Public Schools			
	17. Father's Name (First, Middle, Last) James A. Holmes				18. Mother's Name (First, Middle, Maiden Surname) Maranda Phillips			
	19a. Informant's Name/Relationship (Type, Print) Robert Scott - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3708 Portal Ave., Temple Hills, MD 20748			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Riverview Memorial Gardens		Date 2/6/1999		20c. Location - City or Town, State Charleston, SC	
	21. Signature of Funeral Service Licensee <i>Tyrone J. Young</i>				22. Name and Address of Facility Tyrone J. Young Funeral Services 719 Kennedy Street, NW Washington, DC 20011			
	23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Metastatic Cancer of the Breast</i>				Due to (or as a consequence of):		Approximate Interval Between Onset and Death years	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. <i>Cardiomyopathy</i>				Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cardiomyopathy</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Surinder Singh</i>		29c. License number D28920 Maryland		29d. Date signed (Month, Day, Year) 1-31-1999		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SURINDER SINGH 7319A Hanover Parkway, Greenbelt, MD, 20770								
31. Date filed (Month, Day, Year) FEB 04 1999		32. Registrar's Signature <i>S. Singh</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04816

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jules Sternberg

2. Date of Death  
Month

Day

Year

January 31, 1999

3. Time of Death

3:00 AM

4a. Facility Name (If not institution, give street and number)

The Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

213-46-7521

6. Sex

M 2 F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 12, 1914

9. Birthplace (State or Foreign Country)

Transylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

Yes 2 No

10e. Street and Number

5809 Edson Lane

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Pharmacist

16b. Kind of Business/Industry

Medicine

17. Father's Name (First, Middle, Last)

Jacob Sternberg

18. Mother's Name (First, Middle, Maiden Surname)

Hermina Steiner

19a. Informant's Name/Relationship (Type, Print)

Susanna Sternberg/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5809 Edson Lane, Rockville, Maryland 20852

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Lebanon Cemetery

Data

Feb.

01/1999

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Takoma Funeral Home

254 Carroll Street, NW, Washington, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

b. DEMENTIA VASCULAR

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 18084

29d. Date signed (Month, Day, Year)

January 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. D. PATEL, M.D. 6121 Montrose Rd, Rockville MD 20852

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

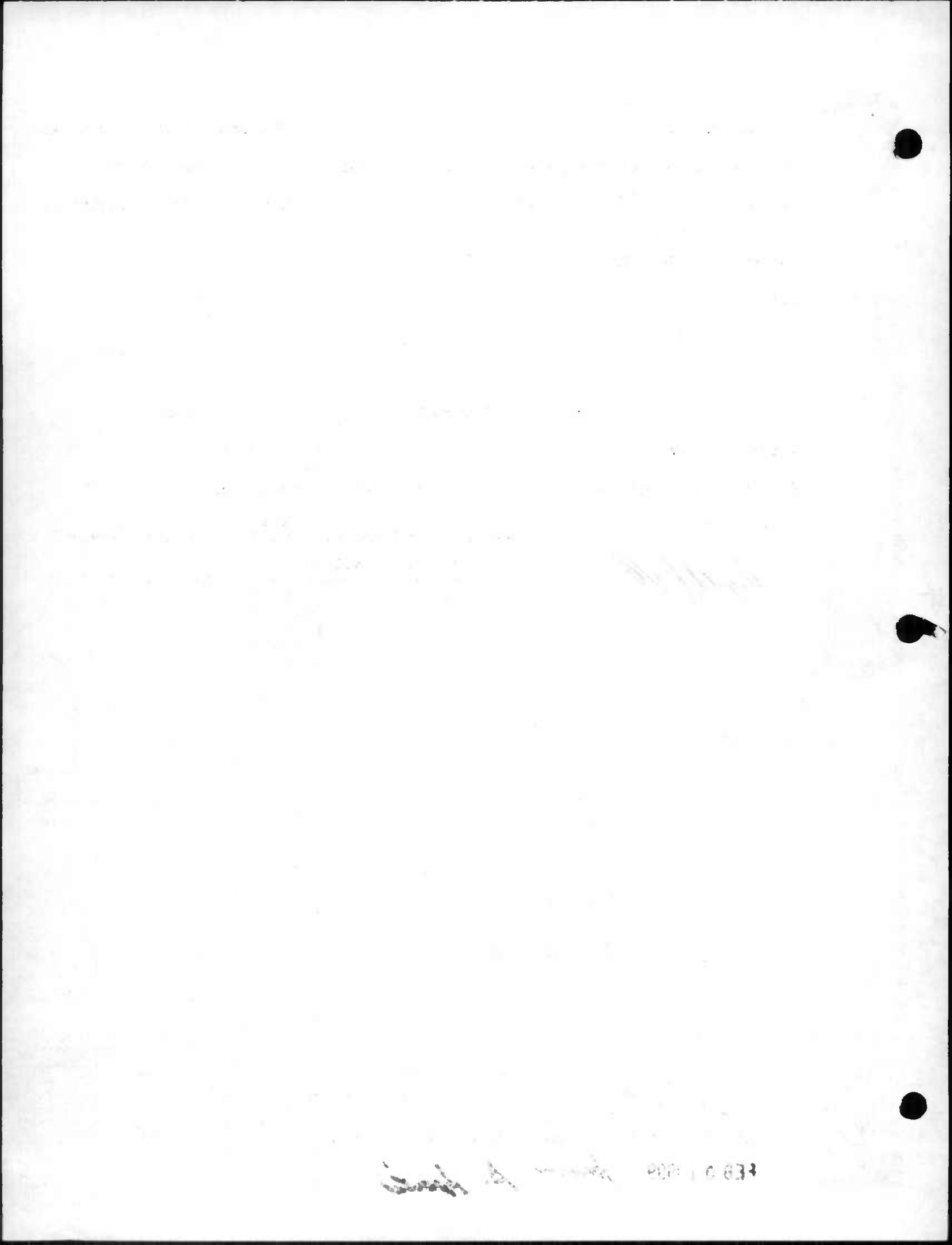
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04817

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frank James Svoboda, Sr.

2. Date of Death

January 28 1999

3. Time of Death

2:05 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

577-26-8692

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 8, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Seabrook

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9505 Mazzoni Avenue

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1943-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Paper Company

17. Father's Name (First, Middle, Last)

Joseph Svoboda

18. Mother's Name (First, Middle, Maiden Surname)

Viola Marie Schultz

19a. Informant's Name/Relationship (Type, Print)

Elsie Gladys Svoboda - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9505 Mazzoni Avenue, Seabrook, Maryland 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veteran's Cemetery

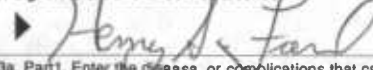
Date

02/01/99

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Advanced Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

COPD Pulmonale

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Swallowing Difficulty

Due to (or as a consequence of):

Aspiration Pneumonia

Approximate Interval Between Onset and Death

2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Status Post Rt Lobectomy Secondary to carcinoma of the lung

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D40541

29d. Date signed (Month, Day, Year)

01-30-99

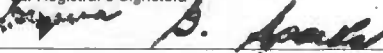
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christie I. Okeke, M.D. 9801 Greenbelt Road #210, Lanham, Maryland 20706

31. Date filed (Month, Day, Year)

FEB 01 1999

32. Registrar's Signature

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04818

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ERNEST LEE SHREVE						2. Date of Death Month Day Year February 3, 1999		3. Time of Death 2:00 am																																																																												
	4a. Facility Name (If not institution, give street and number) Memorial Hospital						4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany																																																																												
Funeral Director	5. Social Security Number 220-28-9668		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) NOV 6 1931		9. Birthplace (State or Foreign Country) MARYLAND																																																																												
	Usual Residence of Decedent																																																																																				
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																																																												
	10e. Street and Number 135 NORTH MECHANIC STREET				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.																																																																														
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No U.S. ARMY If Yes, Give Year or Dates: KOREAN		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE																																																																													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CONSTRUCTION			16b. Kind of Business/Industry CONSTRUCTION																																																																													
	17. Father's Name (First, Middle, Last) ARLEY BERRY SHREVE						18. Mother's Name (First, Middle, Maiden Surname) HAZEL VIOLA LEWIS																																																																														
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) SANDRA DOLLY SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RFD#5 BOX#803 KEYSER, W.VA. 26726																																																																																
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) REST LAWN CEMETERY FEBRUARY 5 1999		20c. Location - City or Town, State LAVALE MARYLAND																																																																														
	21. Signature of Funeral Service Licensee Dale L. Merritt				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND																																																																																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																																																																				
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="9">e. ACUTE RESPIRATORY FAILURE</td> <td rowspan="4">Approximate Interval Between Onset and Death 3 weeks</td> </tr> <tr> <td colspan="9">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="9">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="9">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="4">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td colspan="9">d. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</td> <td rowspan="4">10 years</td> </tr> <tr> <td colspan="9">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="9">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="9">Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	e. ACUTE RESPIRATORY FAILURE									Approximate Interval Between Onset and Death 3 weeks	Due to (or as a consequence of):									Due to (or as a consequence of):									Due to (or as a consequence of):									Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	d. CHRONIC OBSTRUCTIVE PULMONARY DISEASE									10 years	Due to (or as a consequence of):									Due to (or as a consequence of):									Due to (or as a consequence of):							
Immediate Cause (Final disease or condition resulting in death)	e. ACUTE RESPIRATORY FAILURE									Approximate Interval Between Onset and Death 3 weeks																																																																											
	Due to (or as a consequence of):																																																																																				
	Due to (or as a consequence of):																																																																																				
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Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	d. CHRONIC OBSTRUCTIVE PULMONARY DISEASE									10 years																																																																											
	Due to (or as a consequence of):																																																																																				
	Due to (or as a consequence of):																																																																																				
	Due to (or as a consequence of):																																																																																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																																																																													
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																																																													
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																																																													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																																																																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																																																																											
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																																																													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Dr. Q. Zaman				29c. License number D 23371		29d. Date signed (Month, Day, Year) February 4, 1999																																																																											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Q. Zaman, Johnson Heights Medical Bldg., Cumberland, MD 21502																																																																																					
31. Date filed (Month, Day, Year) FEB 05 1999				32. Registrar's Signature [Signature]																																																																																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ERNEST SHREVE 220-28-9668

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04819

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN KENNETH SPENCER				2. Date of Death Month Day Year JANUARY 28, 1999		3. Time of Death 7:38 P.M.	
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 214-07-1866		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) AUGUST 27 1919	
	9. Birthplace (State or Foreign Country) PA.		10a. State PA.		10b. County BEDFORD		10c. City, Town or Location BEDFORD	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 568 LAKE GORDON ROAD		10f. Zip Code 15522	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW11	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Collega (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CELANESE CORP OF AMERICA				16b. Kind of Business/Industry MANUF. SILK			
	17. Father's Name (First, Middle, Last) GEORGE HENRY SPENCER				18. Mother's Name (First, Middle, Maiden Surname) EFFIE NANCY MCCOY			
	19a. Informant's Name/Relationship (Type, Print) GOLDIE P. SPENCER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE 568 LAKE GORDON ROAD BEDFORD, PA. 15522			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET CEMETERY JANUARY 31 1999 CUMBERLAND MARYLAND			
	21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Respiratory failure</i> Due to (or as a consequence of): b. <i>Bilateral pneumonia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 months 2 months			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Aortic Valve Replacement</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>				
29c. License number D33280				29d. Date signed (Month, Day, Year) Jan, 29, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR SUNIL K. GUPTA 625 KENT AVE. CUMBERLAND MARYLAND 21502				31. Date filed (Month, Day, Year) FEB 01 1999				
32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

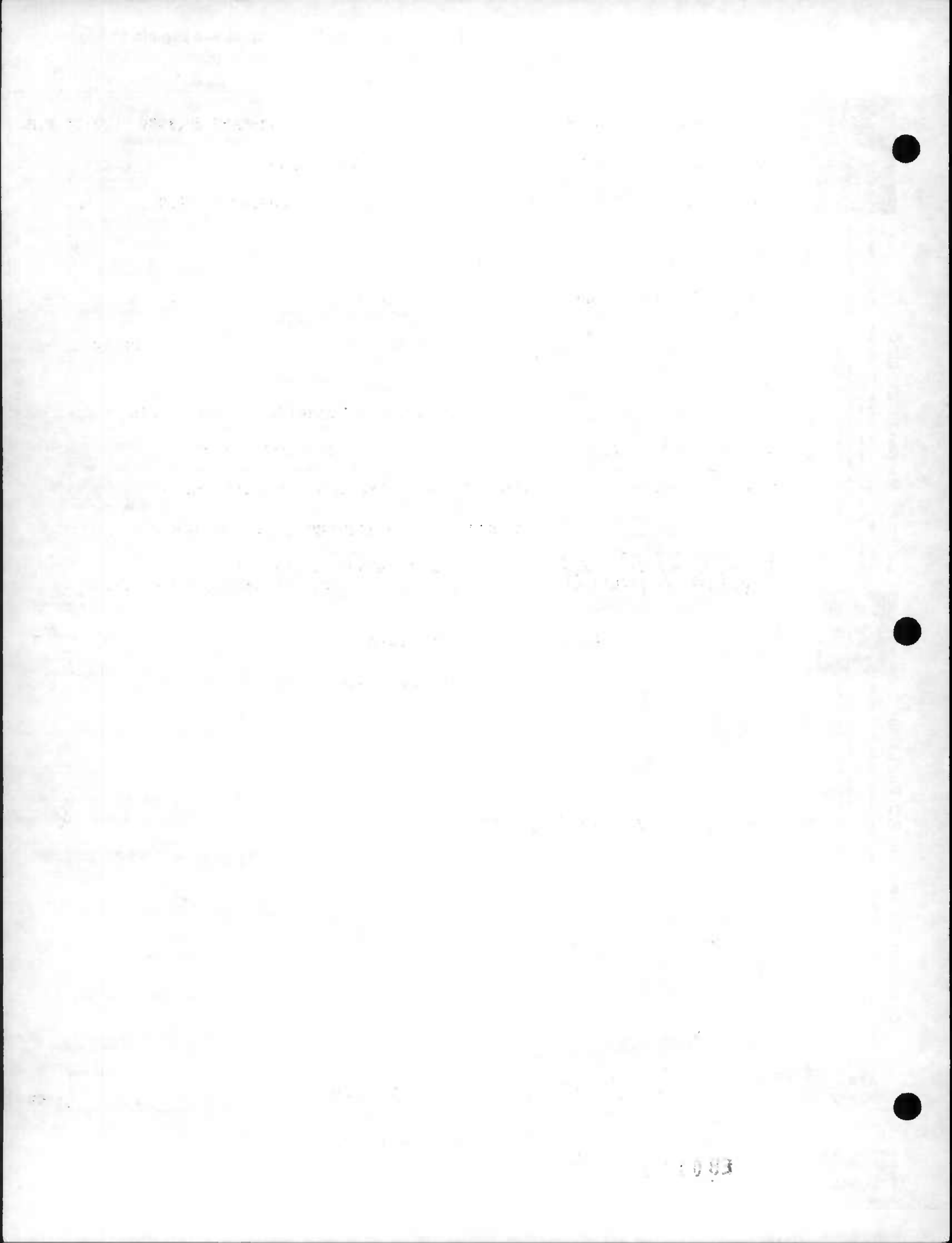
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

7

*[Signature]*



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04820

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GILBERT L. SAELER				2. Date of Death Month Day Year January 27, 1999		3. Time of Death 1850		
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany		
Funeral Director	5. Social Security Number 10 8525		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 94	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 7-3-04	9. Birthplace (State or Foreign Country) WV	
	Usual Residence of Decedent								
10a. State MD		10b. County Allegany		10c. City, Town or Location Ellerslie			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number PO Box 441				10f. Zip Code 21529		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Columbia Energy Group			16b. Kind of Business/Industry Utilities		
17. Father's Name (First, Middle, Last) Charles P. Saeler				18. Mother's Name (First, Middle, Maiden Surname) Emma Mae Brady					
19a. Informant's Name/Relationship (Type, Print) Charles Saeler/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 121, Ellerslie, MD 21529					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Broad Run Cemetery		Date 1-30-99		20c. Location - City or Town, State Jane Lew, WV		
21. Signature of Funeral Service Licensee Harvey H. Zeigler				22. Name and Address of Facility Harvey H. Zeigler Funeral Home Hyndman, PA 15545					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
a. <i>Acute Respiratory Failure</i> 24 h Due to (or as a consequence of):								24 h	
b. <i>Aspiration</i> 24 h Due to (or as a consequence of):								24 h	
c. <i>GI Bleeding</i> 24 h Due to (or as a consequence of):								24 h	
d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier			29c. License number 208377		29d. Date signed (Month, Day, Year) January 29, 1999	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 924 Seton Dr, Cumberland MD 21502									
31. Date filed (Month, Day, Year) FEB 02 1999			32. Registrar's Signature						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 01 021

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mario Victor Smirollo

2. Date of Death

February 05 99

3. Time of Death

2:15 PM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579 66 3177

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 24, 1949

9. Birthplace (State or Foreign)

Italy

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Clinton

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6307 Edward Drive

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Store Manager

16b. Kind of Business/Industry

Merchants Tire

17. Father's Name (First, Middle, Last)

Giuseppe Smirollo

18. Mother's Name (First, Middle, Maiden Surname)

Antonina Palella

19a. Informant's Name/Relationship (Type, Print)

Salvatrice Smirollo (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6307 Edward Drive, Clinton, Maryland 20735

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Resurrection Cemetery 2/9/99

Data

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Lee Funeral Home, Inc 6633 Old  
Alexandria Ferry Road, Clinton, Maryland 2073523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Massive intracerebral hemorrhage  
Due to (or as a consequence of):

3 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Possible mild diabetes  
Due to (or as a consequence of):

uncertain

c. Borderline hypertension  
Due to (or as a consequence of):

uncertain

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

J22026

29d. Date signed (Month, Day, Year)

2/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sharon L. Marselas, M.D. 12070 Old Line Center, Suite 205, Waldorf MD. 20602

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 09 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 01,822

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas McQuiston Sykes				2. Date of Death Month Day Year Feb. 2, 1999		3. Time of Death 1515	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 415-24-0222		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 5, 1918	
	9. Birthplace (State or Foreign Country) Mississippi		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 709 Maiden Choice Lane #6106		10f. Zip Code 21228	
	10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1963		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Officer - Major	
	16b. Kind of Business/Industry U.S. Air Force Ret.				17. Father's Name (First, Middle, Last) Thomas M. Sykes, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Minnie Dameron	
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Thomas Sykes, Jr. (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3711 Falling Green Way Mt. Airy, Maryland 21771			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery		20c. Location - City or Town, State Arlington, Virginia	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735			
	23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. Pneumonia Due to (or as a consequence of): b. Acute respiratory failure Due to (or as a consequence of): c. Acute renal failure Due to (or as a consequence of): d. Electrolyte imbalance				Approximate Interval Between Onset and Death 9 9 9 9			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Hypertensive Heart Disease old Stroke				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Vincent Ganti			
	29c. License number D41162				29d. Date signed (Month, Day, Year) 2-3-1999			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) V. Ganti 1989, Doctor Drive G'town MD 20874				31. Date filed (Month, Day, Year) FEB 04 1999			
	32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

99 04823

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donald Walter STOCKMAN				2. Date of Death Month Day Year February 02, 1999		3. Time of Death 01:30 am	
	4e. Facility Name (If not institution, give street and number) 3908 Lander Road				4b. City, Town, or Location of Death Jefferson		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 219-36-2606	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth May 23, 1923	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10e. State Maryland		10b. County Frederick		10c. City, Town or Location Jefferson		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 3908 Lander Road				10f. Zip Code 21755		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dairy farmer			16b. Kind of Business/Industry Farming	
	17. Father's Name (First, Middle, Last) Paul Arlington Stockman				18. Mother's Name (First, Middle, Maiden Surname) Hattie Elizabeth Ahalt			
Physician /Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Catherine Huffer Stockman/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3908 Lander Road, Jefferson, Maryland 21755			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		Date Feb. 5, 1999		20c. Location - City or Town, State Frederick, Maryland	
	21. Signature of Funeral Service Licensee Richard C. Bradford M00021				22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Approximate Interval Between Onset and Death							
Medical Certification: To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)				a. <u>extremely late impotence</u> Due to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				b. <u>renal failure</u> Due to (or as a consequence of):			
					c. <u>transitional cell ca</u> Due to (or as a consequence of):			
					d. <u>bladder &amp; kidney 2 yrs</u>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>lung metastases</u>							
State Registrar	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D14626		29d. Date signed (Month, Day, Year) February 2, 1999		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) P. Gregory Rausch, M.D., 501 West Seventh Street, Frederick, Maryland 21701								
31. Date filed (Month, Day, Year) FEB 04 1999				32. Registrar's Signature 				



B.K.S

DANIEL PATRICK SHERIDAN

**Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, PER MEO G769 3-1-99 WR.

### Certificate of Death

Reg. No. 99 01,821

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

State Registrar

1. Decedent's Name (First, Middle, Last)  
Daniel Patrick SHERIDAN

2. Date of Death  
Month FEB. Day 8, Year 1999

3. Time of Death  
0650 AM

4a. Facility Name (If not institution, give street and number)  
8430 WOODSIDE COURT

4b. City, Town, or Location of Death  
OWINGS

4c. County of Death  
CALVERT

5. Social Security Number  
214 52 8366

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)  
49 Yrs.

8. Date of Birth (Month, Day, Year)  
March 5, 1949

9. Birthplace (State or Foreign Country)  
Annapolis, MD

10a. State  
Maryland

10b. County  
Calvert

10c. City, Town or Location  
Owings

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number  
8430 Woodside Court

10f. Zip Code  
20736

10g. Citizen of What Country?  
USA

11. Marital Status  
1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: white

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)  
5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
attorney

16b. Kind of Business/Industry  
self employed lawyer

17. Father's Name (First, Middle, Last)  
Anthony Sheridan

18. Mother's Name (First, Middle, Maiden Surname)  
Margaret Mary Hornlein

19a. Informant's Name/Relationship (Type, Print)  
Catherine Ann Sheridan / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
same as # 10 above

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
St. John Vianney Cemetery 2-12-99

20c. Location - City or Town, State  
Prince Frederick, MD

21. Signature of Funeral Service Licensee  
William R. Irons

22. Name and Address of Facility  
Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)  
a. CARDIAC ARRHYTHMIA  
Due to (or as a consequence of):  
b. CARDIAC HYPERTROPHY  
Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):  
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death  
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury  
M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  
J. ALON LOCKE, MD

29c. License number  
O.C.M.E

29d. Date signed (Month, Day, Year)  
FEB. 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
J. ALON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)  
FEB 19 1999

32. Registrar's Signature  
B. Smith



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 04825

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EMMA, I. Shaw</b>				2. Date of Death Month <b>1</b> Day <b>31</b> Year <b>99</b>		3. Time of Death <b>16:30</b>	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>218-44-1130</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 26, 1920</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>			10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
10e. Street and Number <b>513 Knollwood Dr.</b>				10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerical</b>			16b. Kind of Business/Industry <b>Insurance</b>	
17. Father's Name (First, Middle, Last) <b>Benjamin F. Leitch</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Catterton</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Carolyn P. Sherbert / daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>849 Arundel Dr. Arnold, Md. 21012</b>				
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Cemetery</b>		Data <b>2-4-99</b>		20c. Location - City or Town, State <b>Glen Burnie, Md.</b>	
21. Signature of Funeral Service Licensee <b>E. Brian Powell</b>				22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Sepsis</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>8 days</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No						24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No		
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No			26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)			28e. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <b>Marco A. Mejia, MD</b>			29c. License number <b>D46303</b>		29d. Date signed (Month, Day, Year) <b>2/1/99</b>
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARCO A. MEJIA M.D. 900 Bartgate Suite 300 Annapolis MD 21401</b>								
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>			32. Registrar's Signature <b>B. Smith</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

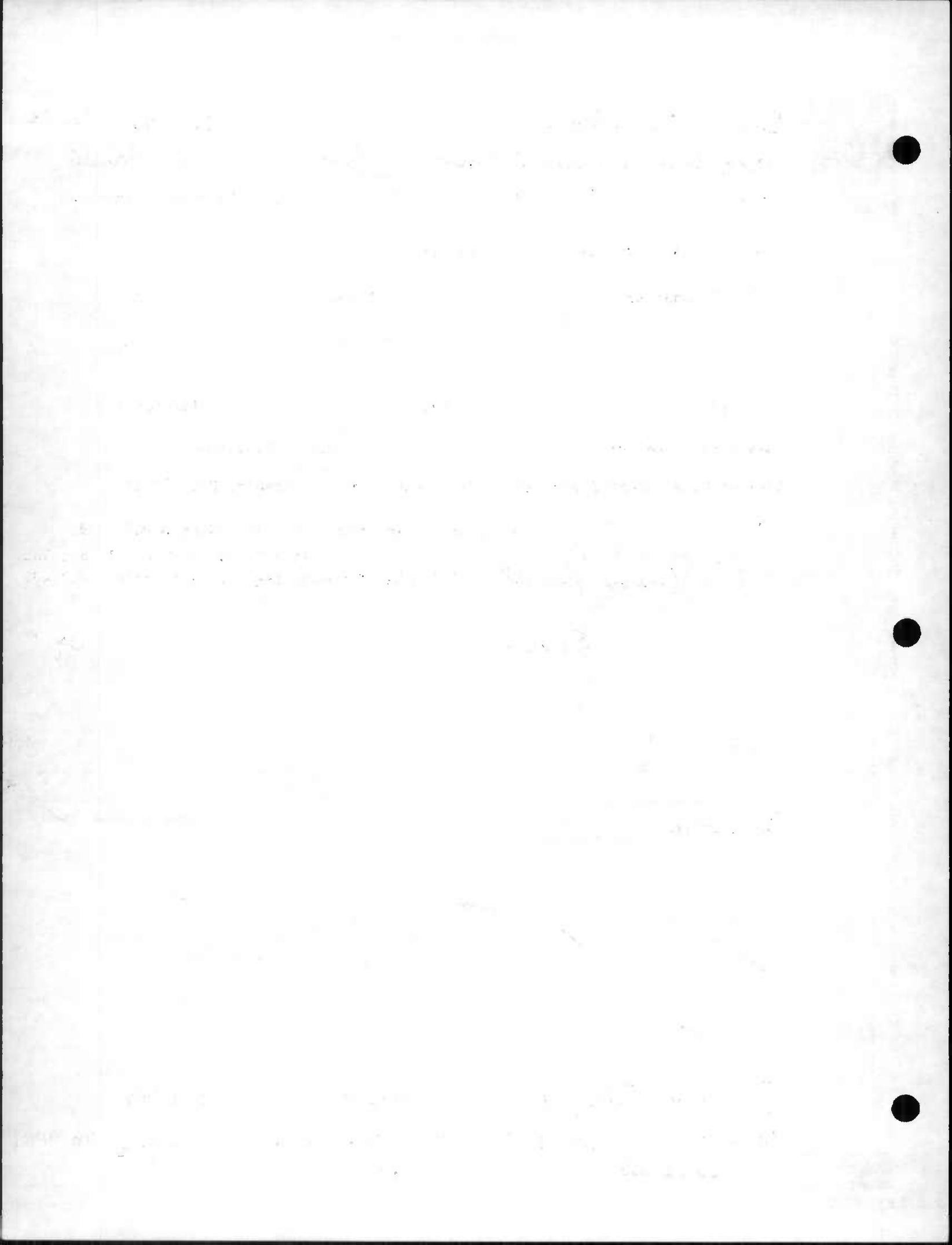
Important: If item 27 is marked other than "natural," or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04826

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arthur Shaver, Jr.				2. Date of Death Month Day Year January 31, 1999				3. Time of Death 12:05 AM	
	4a. Facility Name (If not institution, give street and number) 705 Sydney Terrace				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 057-24-9953	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	8. Date of Birth (Month, Day, Year) Mar. 25, 1926	9. Birthplace (State or Foreign Country) New York					
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 705 Sydney Terrace				10f. Zip Code 21401		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Doctor		16b. Kind of Business/Industry Medical			
	17. Father's Name (First, Middle, Last) Arthur Shaver, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Simpson					
	19a. Informant's Name/Relationship (Type, Print) Mary Jo Shaver/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 Sydney Terrace Annapolis, MD 21401					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		Date 2-3-99		20c. Location - City or Town, State Clinton, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. METASTATIC LUNG CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Peter R. Graze M.D. 29c. License number D16364 29d. Date signed (Month, Day, Year) 2/1/99										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter R. Graze, M.D. 900 Bestgate Rd. Suite 300, Annapolis, Maryland 21401										
31. Date filed (Month, Day, Year) FEB 02 1999 32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04827

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT WELLINGTON TOWNSHEND</b>				2. Date of Death Month <b>February</b> Day <b>4</b> Year <b>1999</b>		3. Time of Death <b>12:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>10505 Cedarville Road #1015</b>				4b. City, Town, or Location of Death <b>Brandywine</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>217-36-7591</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>64</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 20, 1935</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>							
Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Brandywine</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>10505 Cedarville Road #1015</b>				10f. Zip Code <b>20613</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Correctional Officer</b>		16b. Kind of Business/Industry <b>County Government</b>		
17. Father's Name (First, Middle, Last) <b>John Oscar Townshend</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Louise Hyde</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Lee Townshend/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10505 Cedarville Rd. #1015, Brandywine, Md 20613</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St Paul's Cemetery</b>		Date <b>02-08-1999</b>		20c. Location - City or Town, State <b>Brandywine, Md.</b>		
21. Signature of Funeral Service Licensee <b>DAVID A. GOFF</b>				Name and Address of Facility <b>The Hunt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604</b>				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Lung Cancer</b> Due to (or as a consequence of): b. <b>RENAL Failure due to Advanced FDDM</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospital</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>YAHYA SARI M.D.</b>						
		29c. License number <b>D38954</b>		29d. Date signed (Month, Day, Year) <b>2/8/99</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>YAHYA SARI 2 Post Office Road, #3, Waldorf, Maryland</b>								
31. Date filed (Month, Day, Year) <b>2/8/99 FEB 09 1999</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04828

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PEARL E. TUTSON				2. Date of Death Month Day Year FEBRUARY 3, 1999				3. Time of Death 2:55 pm	
	4a. Facility Name (If not institution, give street and number) MANOR CARE OF BETHESDA				4b. City, Town, or Location of Death BETHESDA				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 578-03-6455		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 3, 1905		9. Birthplace (State or Foreign Country) Washington, D.C.	
	Usual Residence of Decedent				10a. State Maryland		10b. County Montgomery		10c. City, Town or Location ROCKVILLE	
To Be Completed by Funeral Director	10e. Street and Number 138 Monroe Street		10f. Zip Code 20950		10g. Citizen of What Country? United States		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Private Home					
	17. Father's Name (First, Middle, Last) William B. Stevenson				18. Mother's Name (First, Middle, Maiden Surname) Agnes Unk.					
	19a. Informant's Name/Relationship (Type, Print) Bernard Tutson, II / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 138 Monroe Street, Rockville, Maryland 20950					
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LINCOLN MEMORIAL CEM.		20c. Location - City or Town, State Suitland, Maryland		20d. Date 2/11/99			
	21. Signature of Funeral Service Licensee  M859				22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES 2617 Pennsylvania Avenue, S.E. Wash., DC 20020					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) a. ALZHEIMERS DISEASE Due to (or as a consequence of):								1994	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. A S I V D Due to (or as a consequence of):								1994	
c. UBD Due to (or as a consequence of):								1994		
d. CVA Due to (or as a consequence of):								1994		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AREMIA								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  MD				29c. License number D17729		29d. Date signed (Month, Day, Year) February 4, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. G.B. PATRICK 9221 Colesville Road, Silver Spring, Md 20906										
31. Date filed (Month, Day, Year) FEB 05 1999		Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

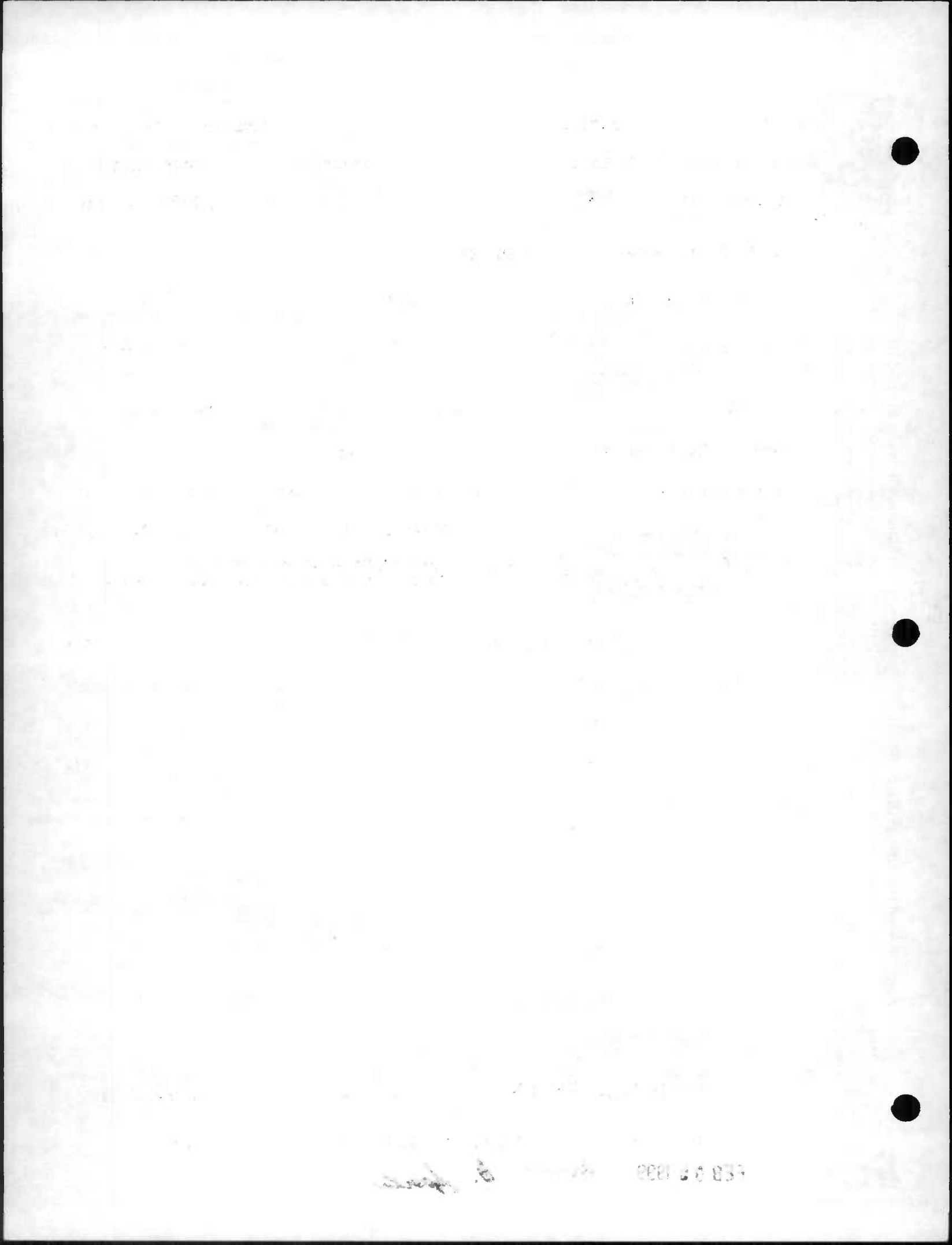
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



FEB 2 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04829

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roy L. Thomas, Sr.				2. Date of Death Month Day Year January 29 1999		3. Time of Death 11:45AM	
	4a. Facility Name (If not institution, give street and number) 5503 Linwood Court				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 232-07-7476		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 9, 1917	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Lanham	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 5503 Linwood Court		10f. Zip Code 20706		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Government			
	17. Father's Name (First, Middle, Last) Jonah Thomas		18. Mother's Name (First, Middle, Maiden Surname) Annie Lawson		19a. Informant's Name/Relationship (Type, Print) Barbara Harris - Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5503 Linwood Ct., Lanham, MD 20706	
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Date 2/5/99		20c. Location - City or Town, State Brentwood, MD	
	21. Signature of Funeral Service Licensee John T. Stewart, III		22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute myocardial infarction Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Alzheimer's disease		Approximate Interval Between Onset and Death	
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
State Registrar	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Don B. Cameron M.D.		29c. License number D01808		29d. Date signed (Month, Day, Year) 2-1-99	
5	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DON B. CAMERON, M.D. 6005 LANDOVER RD CHEVERLY, MD 20785		31. Date filed (Month, Day, Year) FEB 02 1999					
	32. Registrar's Signature [Signature]							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04830

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MICHAEL TYLER Sr.</b>				2. Date of Death Month <b>JAN</b> Day <b>28</b> Year <b>99</b>		3. Time of Death <b>7:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>FORT WASHINGTON HOSPITAL</b>				4b. City, Town, or Location of Death <b>FORT WASHINGTON</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>577-68-7242</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>48</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>7-16-1950</b>	
	9. Birthplace (State or Foreign Country) <b>WASH.DC</b>		10a. State <b>MD</b>		10b. County <b>PRINCE GEORGES</b>		10c. City, Town or Location <b>FT. WASHINGTON</b>	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1115 PALMER ROAD, #13</b>		10f. Zip Code <b>20744</b>		
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1970-72</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MOTOR VEHICLE OPERATOR</b>		16b. Kind of Business/Industry <b>DEPT. OF THE ARMY</b>		
17. Father's Name (First, Middle, Last) <b>HENRY TYLER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CATHERINE DORSEY</b>				
19a. Informant's Name/Relationship (Type, Print) <b>BRENDA TYLER - WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1115 PALMER RD., #13 FT. WASHINGTON, MD 20744</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MINOR FAMILY CEMETERY</b>		20c. Location - City or Town, State <b>2-3- BUMPASS, VIRGINIA</b>		20d. Date <b>1999</b>		
21. Signature of Funeral Service Licensee <i>B.C. Taylor</i>				22. Name and Address of Facility <b>TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH.DC 20001</b>				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Anoxic encephalopathy</b> Due to (or as a consequence of):</p> <p>b. <b>Acute Respiratory failure AND arrest</b> Due to (or as a consequence of):</p> <p>c. <b>Staphylococcal pneumonia</b> Due to (or as a consequence of):</p> <p>d. <b>Lung CANCER</b></p> </div> <div> <p>Approximate Interval Between Onset and Death <b>15 days</b></p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alcoholism</b> <b>Diabetes mellitus</b> <b>seizure disorder</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Deirdra L. Varner MD</i>				29c. License number <b>D33512</b>		29d. Date signed (Month, Day, Year) <b>1/29/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DEIDRA L. VARNER, MD 10274 LAKE ARBOR WAY, MITCHELLVILLE, MD 20721</b>								
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04831

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BERYL L. TAYLOR				2. Date of Death Month Day Year February 1, 1999		3. Time of Death 10:15 PM		
	4a. Facility Name (If not institution, give street and number) Althea Woodland Nursing Home				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 578-06-2637		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) July 25, 1921		
	9. Birthplace (State or Foreign Country) Jamaica		10a. State MD		10b. County Montgomery		10c. City, Town or Location Bethesda		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 4521 East West Highway, #1410		10f. Zip Code 20814		10g. Citizen of What Country? Permanent Resident /USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian		16b. Kind of Business/Industry Schools					
17. Father's Name (First, Middle, Last) Nathan Nisbeth		18. Mother's Name (First, Middle, Maiden Surname) Unknown		19a. Informant's Name/Relationship (Type, Print) Jolice M. Taylor - Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8120 Sheffield Ct., Jessup, MD 20794			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cemetery		20c. Location - City or Town, State Adelphi, MD		20d. Date 2-6-99			
21. Signature of Funeral Service Licensee J. P. Marshall		22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, DC 20011							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Stroke Due to (or as a consequence of):  Diabetes Mellitus Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Hypertension Renal Failure		Approximate Interval Between Onset and Death 2 years 20 years							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hypertension Renal Failure		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Oki Kwon, M.D.		29c. License number D-30927		29d. Date signed (Month, Day, Year) 2-5-99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oki Kwon, M. D. 1104 Spring Street, Suite 201, Silver Spring, MD		31. Date filed (Month, Day, Year) FEB 05 1999		32. Registrar's Signature [Signature]					

To Be Completed by Funeral Director

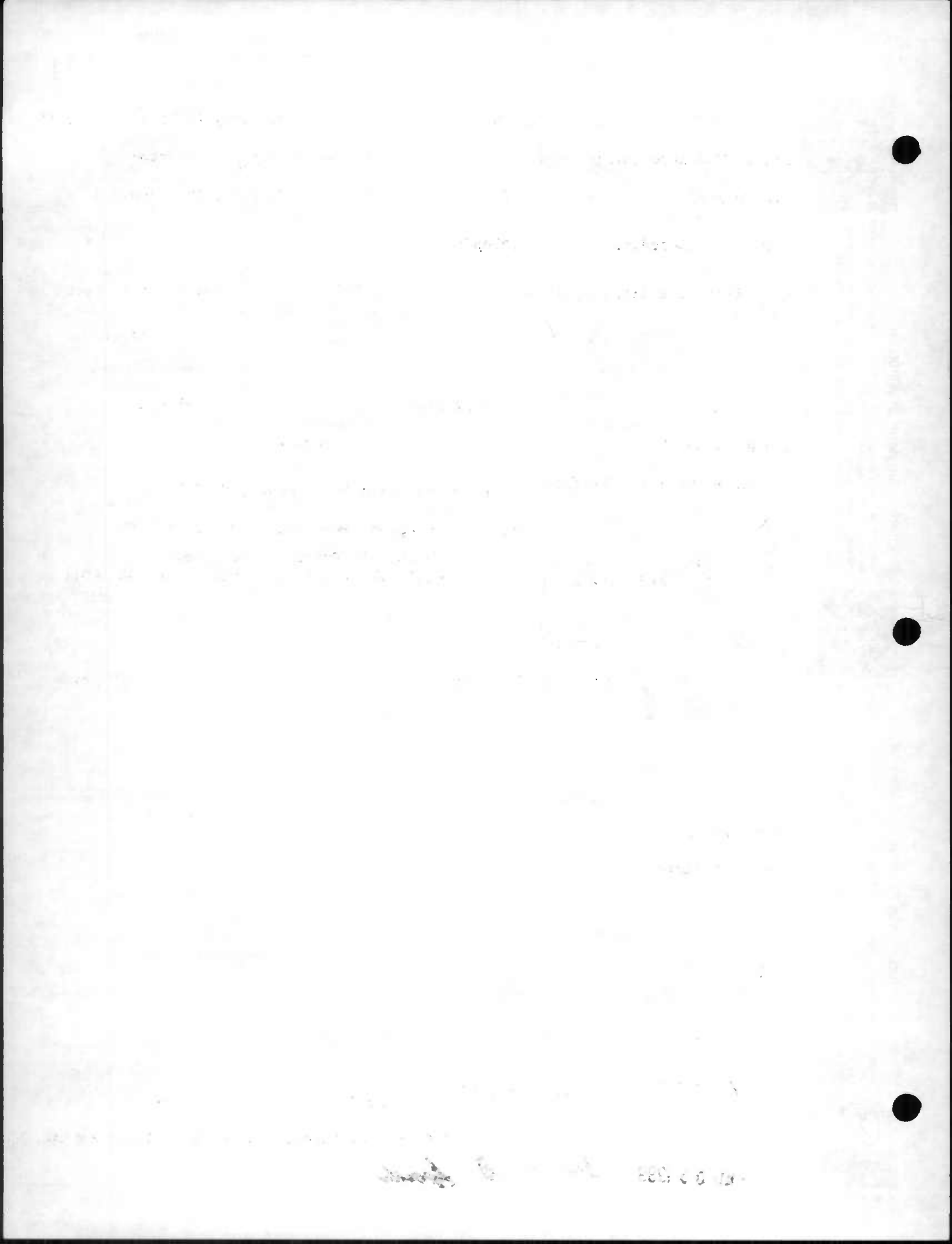
To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

FREDDIE

State of Maryland / Department of Health and Mental Hygiene

THOMPSON JR. ITEM: #8 PER F.H. G769 3-15-99 WR.

Certificate of Death

Reg. No.

99 04832

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FREDDIE WILSON THOMPSON, JR.</b>				2. Date of Death Month Day Year <b>FEBRUARY 11, 1999</b>		3. Time of Death <b>6:28P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>SHOCK TRAUMA CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>239-15-8560</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>42</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>1956</b>		9. Birthplace (State or Foreign Country) <b>Vance, N.C.</b>
	Usual Residence of Decedent							
10a. State <b>N. C.</b>		10b. County <b>Vance</b>		10c. City, Town or Location <b>Henderson</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1691 Ruin Creek Road</b>				10f. Zip Code <b>27536</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Lightning Sales/Installation Rods</b>			16b. Kind of Business/Industry <b>Self-Employed</b>	
17. Father's Name (First, Middle, Last) <b>Freddie Wilson Thompson, Sr.</b>					18. Mother's Name (First, Middle, Maiden Sumama) <b>Vivian Lamb</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Freddie W. Thompson, Sr. Father</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1691 Ruin Creek Rd Henderson, NC 27536</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Gardens</b>			20c. Location - City or Town, State <b>Henderson, N. C.</b>			
21. Signature of Funeral Service Licensee <i>Henry R. Hildner II</i> NC FS 909					22. Name and Address of Facility <b>J.M. White Funeral Home 60 Zeb Robinson Rd., Henderson, NC 27536</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Multiple injuries</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>2-11-99</b>		28b. Time of injury <b>1605 M</b>		28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred <b>Subject fell off roof</b>
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Construction Site</b>						
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>24 Brett Manor Baltimore County, Maryland</b>								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Stephen S. Radentz, MD</i>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 12, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature <i>B. Sparks</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 01833

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEONDA TEMPLEMAN

2. Date of Death

Feb 1 1999

Day Year

3. Time of Death

7:23 PM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Southern Maryland

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577 54 7143

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 9, 1943

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6301 Buttercup Lane

10f. Zip Code

20772

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edwin Jackemeyer

18. Mother's Name (First, Middle, Maiden Surname)

Lilly Ellington

19a. Informant's Name/Relationship (Type, Print)

Bernard Archer (Personal Rep)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6301 Buttercup Lane, Upper Marlboro, Md 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery Feb 5, 1999

Date

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

St. F. Smith

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

HUNTINGTONS CHOREA

Approximate Interval Between Onset and Death

unknown

Due to (or as a consequence of):

b.

SKIN ulcers.

unknown

Due to (or as a consequence of):

c.

on Throat

unknown

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Arastoo Yazdani

29c. License number

50454

29d. Date signed (Month, Day, Year)

Feb 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arastoo Yazdani, M.D. 1328 Southern Ave Suite 202, Washington DC 20032

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

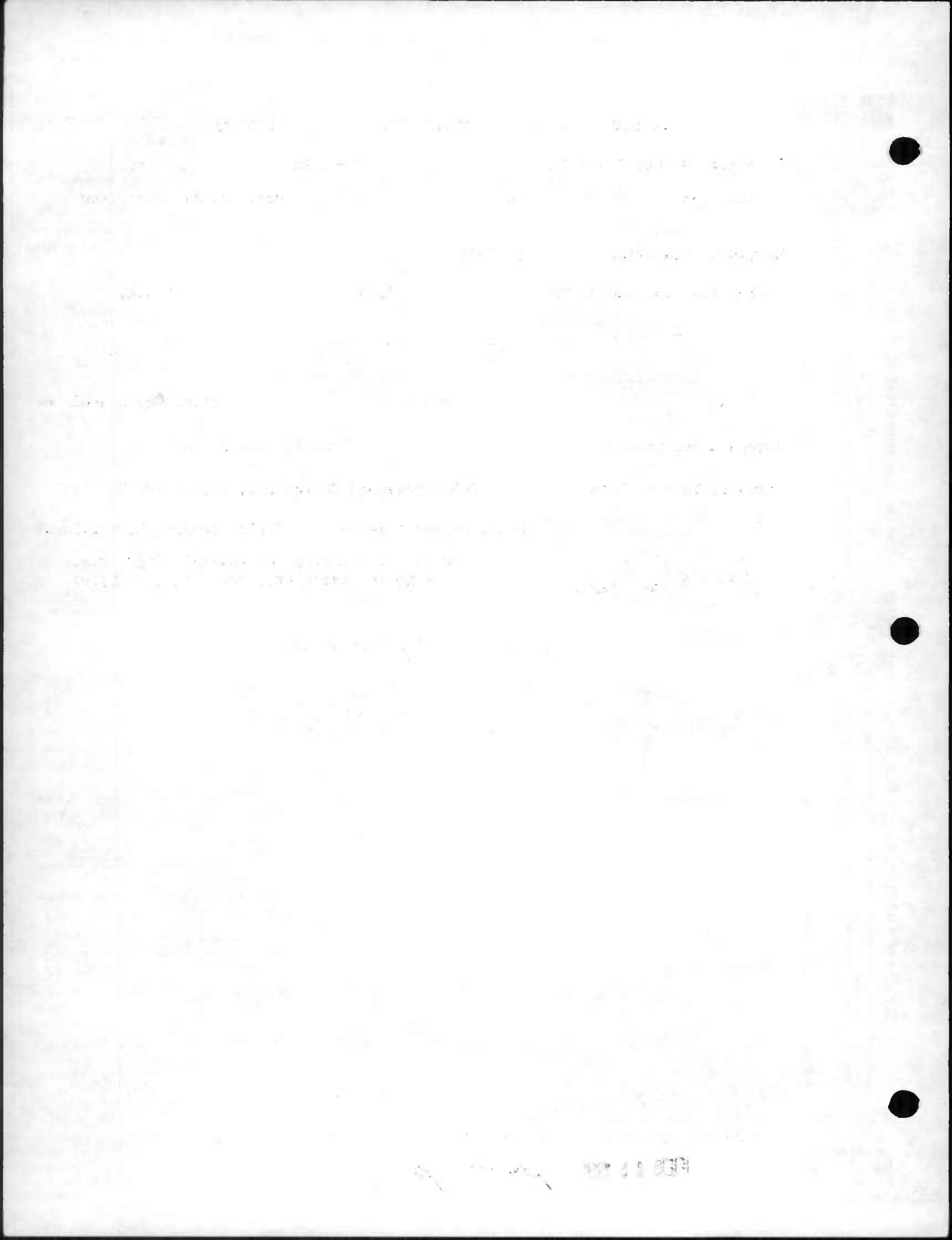
99 04834

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Leonard Allen Thomas Sr.</b>						2. Date of Death Month <b>February</b> Day <b>2</b> Year <b>1999</b>		3. Time of Death <b>3:47 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>						4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>218-24-9409</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 13, 1920</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>7803-A Edgewood Church Road</b>				10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>			16b. Kind of Business/Industry <b>Fred. Co. School Board</b>			
17. Father's Name (First, Middle, Last) <b>Joseph Allen Thomas</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth Stull</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Norma L. Thomas (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7803-A Edgewood Church Rd., Frederick, MD 21702</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Olivet Cemetery</b>		Date <b>2/5/99</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Respiratory failure</b> Due to (or as a consequence of) b. <b>Cardiac insufficiency</b> Due to (or as a consequence of) c. <b>Dilated Myocardium</b> Due to (or as a consequence of) d. Due to (or as a consequence of)										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number <b>D32245</b>		29d. Date signed (Month, Day, Year) <b>2/2/99</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Amy Jones, MD 56 Thomas Johnson Drive, Frederick, Maryland 21701</b>										
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04835

KB

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLYDE WILLIAM TOPPER				2. Date of Death Month Day Year JANUARY 31, 1999		3. Time of Death 2:00 PM	
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL				4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK	
Funeral Director	5. Social Security Number 162-26-5059		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 4, 1932	
	9. Birthplace (State or Foreign Country) EMMITSBURG, MD.		10a. State MD		10b. County FREDERICK		10c. City, Town or Location ROCKY RIDGE	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 9714 FOUR POINTS RD.		10f. Zip Code 21778		10g. Citizen of What Country? U. S. A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER		16b. Kind of Business/Industry CONCRETE				
17. Father's Name (First, Middle, Last) JACOB JOHN TOPPER				18. Mother's Name (First, Middle, Maiden Surname) HELEN MYERS				
19a. Informant's Name/Relationship (Type, Print) FRANCES RAE TOPPER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9714 FOUR POINTS RD., ROCKY RIDGE, MD. 21778				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. ANTHONY'S SHRINE		20c. Location - City or Town, State EMMITSBURG, MD. 21727		20d. Date 2/3/99		
21. Signature of Funeral Service Licensee <i>John M. Skiles</i>		22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727						
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Pulmonary Edema</i> Due to (or as a consequence of): b. <i>Decreased Cardiac Output</i> Due to (or as a consequence of): c. <i>Septic</i> Due to (or as a consequence of): d. <i>Injured Rt Leg</i>								
Approximate Interval Between Onset and Death e. <i>6 hr</i> b. <i>2 WEEKS</i> c. <i>3 WEEKS</i> d. <i>3 WEEKS</i>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ESRD</i> <i>DIABETES mellitus</i> <i>Hypertensive cardiovascular disease</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Mark R. Bell MD</i>		29c. License number <i>D29591</i>		29d. Date signed (Month, Day, Year) <i>1/31/99</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Mark R. Bell MD 201 Thomas Johnson Dr FREDERICK MD 21702</i>								
31. Date filed (Month, Day, Year) FEB 02 1999		32. Registrar's Signature <i>B. [Signature]</i>						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04836

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ETESIN UMOREN

2. Date of Death

Month Day Year  
1 30 99

3. Time of Death

6:05 AM

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF SILVER SPRING

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

227-57-8919

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
3-17-24

9. Birthplace (State or Foreign Country)

Nigeria

Usual Residence of Decedent

10a. State

Maryland

10b. County

PG

10c. City, Town or Location

ADELPHI

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2401 Fordham Place

10f. Zip Code

20783

10g. Citizen of What Country?

Nigeria

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BUSINESS MAN

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

Equere Umoren

18. Mother's Name (First, Middle, Maiden Surname)

Adiah Eteno

19a. Informant's Name/Relationship (Type, Print)

Mfon Umoren

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2401 Fordham Pl, Adelphi, Md. 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Family Cemetery

Date

MAR. 12

20c. Location - City or Town, State

Nigeria

West Africa

21. Signature of Funeral Service Licensee

Jane A. Mateo

22. Name and Address of Facility

Universal Mortuary Inc.  
411 Kennedy St, N.W., Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3uh

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Myron L. Lenkin MD

29c. License number

006674

29d. Date signed (Month, Day, Year)

2/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYRON L. LENKIN MD

2309 SHOREFIELD RD  
WHEATON MD 20902

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04837

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET VEST</b>				2. Date of Death Month Day Year <b>February 1, 1999</b>		3. Time of Death <b>1716</b>	
	4a. Facility Name (If not institution, give street and number) <b>ATLANTIC GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>BERLIN</b>		4c. County of Death <b>WORCESTER</b>	
Funeral Director	5. Social Security Number <b>226-28-4486</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 8, 1925</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Berlin</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>9 Twilight Court-Ocean Pines</b>				10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>Domestic</b>	
17. Father's Name (First, Middle, Last) <b>Muriel S. Taylor</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth Seymour</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Robert E. Vest/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9 Twilight Court, Berlin, MD 21811-1913</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		Date <b>1/3/99</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>		
21. Signature of Funeral Service Licensee <b>David H. Thompson</b> MO1051				22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>UGI Bleed</b> Due to (or as a consequence of): b. <b>Multiple myeloma</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>5 days</b> <b>1 year</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Robert Durkin D.O.</b>		29c. License number <b>H44283</b>		29d. Date signed (Month, Day, Year) <b>2/2/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Durkin D.O. 9646 Heathway Dr Berlin MD 21811</b>								
31. Date filed (Month, Day, Year) <b>FEB 04 1999</b>		32. Registrar's Signature <b>Sparks</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04838

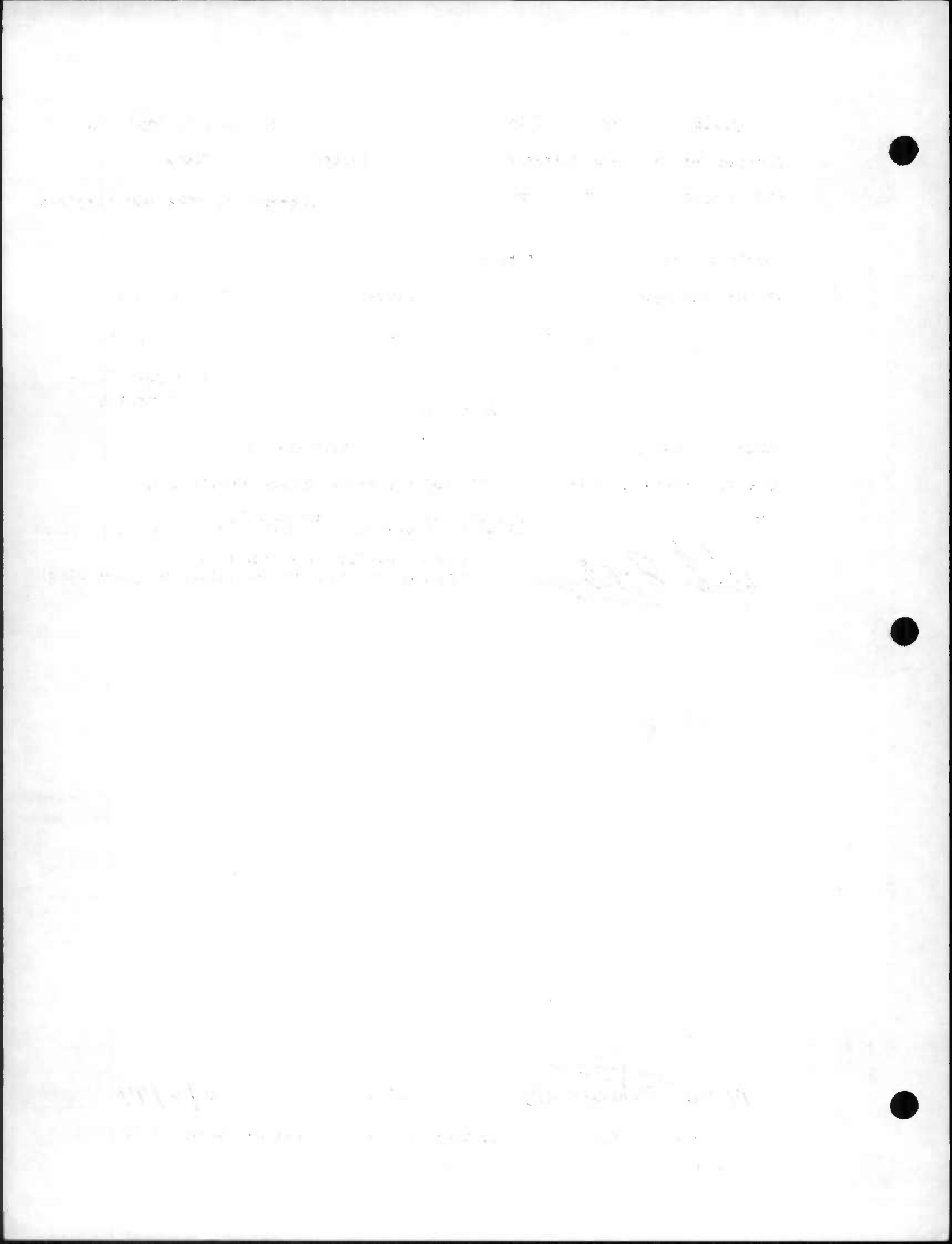
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Phyllis Mary Wright</b>				2. Date of Death Month Day Year <b>February 4, 1999</b>		3. Time of Death <b>1815 P</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sunrise Care and Rehabilitation</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>234-32-0130</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>December 1, 1922</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>115 Maloney Road</b>				10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> Collega (1-4 or 5+) <b>9</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembler</b>		16b. Kind of Business/Industry <b>Electrical Motor Manufacturing</b>		
17. Father's Name (First, Middle, Last) <b>Dominick Paletta</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Cortez</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mary F. Johnson/ Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>115 Maloney Road, Elkton, Maryland 21921</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cherry Hill Methodist Cemetery</b>		Date <b>February 8, 1999</b>		20c. Location - City or Town, State <b>Cherry Hill, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921</b>				
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Lung Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>Years</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>  <b>Anemia</b>  <b>Pneumonia</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  <b>Marc Scheiner M.D.</b>				29c. License number <b>D0053034</b>		29d. Date signed (Month, Day, Year) <b>2/6/99</b>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Marc Scheiner M.D. 223 West Main Street, Elkton, Maryland 21921</b>								
31. Date filed (Month, Day, Year) <b>FEB 08 1999</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,




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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04839

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harrison L. Walls Sr.</b>				2. Date of Death Month Day Year <b>February 2, 1999</b>		3. Time of Death <b>1:55pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince Georges</b>	
Funeral Director	5. Social Security Number <b>214-18-8431</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>February 26, 17</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Clinton</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>7526 Surratts Road</b>		10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Silver Hill Sand Co.</b>				
17. Father's Name (First, Middle, Last) <b>Dorrie Walls</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Susie Walls</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Viola King / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7522 Surratts RD, CLINTON MARYLAND 20735</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Union Bethel Ch.</b>		20c. Location - City or Town, State <b>Feb. 6, 99 Brandywine, Maryland</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Adams Funeral Home P.A., Aquasco, Maryland 20608</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiac shock</b> Due to (or as a consequence of): <b>b. Renal Failure</b> Due to (or as a consequence of): <b>c. Diabetes</b> Due to (or as a consequence of): <b>d. Cardiomyopathy</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pacemaker Placement</b> <b>Cardiac Angiogram</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier 						
29c. License number <b>50454</b>		29d. Date signed (Month, Day, Year) <b>Feb, 3, 1999</b>						
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>Arastoo Yazdani, M.D. 1328 Southern Ave, S.E. #202 Washington D.C.</b>								
31. Date filed (Month, Day, Year) <b>FEB 08 1000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

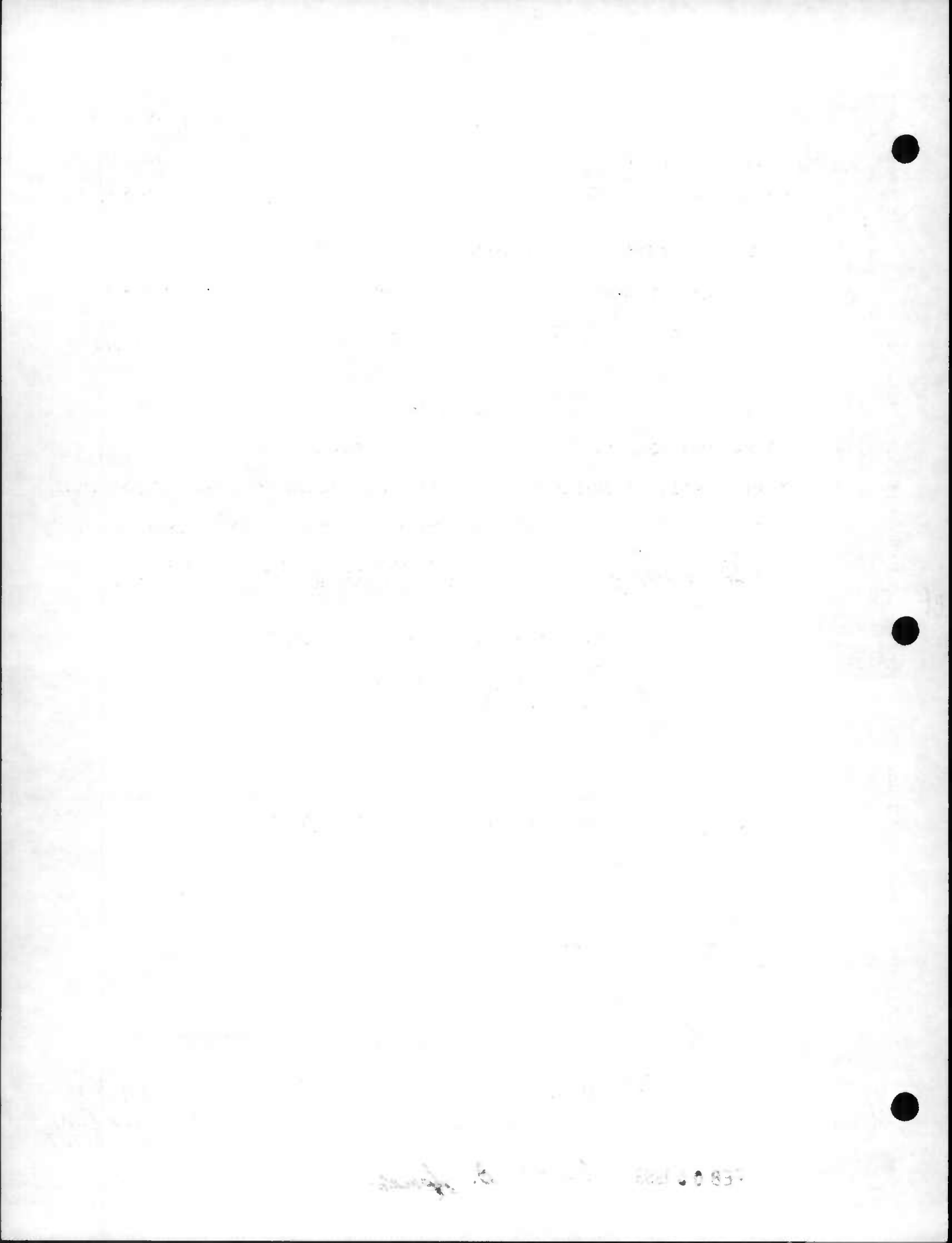
Certificate of Death

Reg. No. 99 04840

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Irene Wayman</b>				2. Date of Death Month Day Year <b>February 1, 1999</b>		3. Time of Death <b>3:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>				4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>218-01-8055</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 10, 1915</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>WHEATON</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>12113 VALLEYWOOD DRIVE</b>				10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>UNITED STATES</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>			16b. Kind of Business/Industry <b>PRIVATE</b>	
17. Father's Name (First, Middle, Last) <b>THOMAS ANDERSON, SR.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE BROWN</b>			
19a. Informant's Name/Relationship (Type, Print) <b>PATRICIA BURRS /DAUGHTER INLAW</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12113 VALLEYWOOD DRIVE, WHEATON, MARYLAND 20902</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD STATE VETERANS CEMETERY</b>			20c. Location - City or Town, State <b>2/8/99 CROWNSVILLE, MD</b>		
21. Signature of Funeral Service Licensee <b>[Signature]</b> M859				22. Name and Address of Facility <b>ALEXANDER S. POPE FUNERAL HOMES 2617 Pennsylvania Avenue, SE DC 20020</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. multilobe pneumonia</b> Due to (or as a consequence of): <b>b. Dehydration</b> Due to (or as a consequence of): <b>c. Diabetes</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MULTI - INFARCT DEMENTIA</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>						
		29c. License number <b>D0053801</b>			29d. Date signed (Month, Day, Year) <b>2/2/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LAURA WERER MD 8317 Cherry Lane Laurel MD 20707</b>								
31. Date filed (Month, Day, Year) <b>FEB 05 1999</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04841

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

JESSIE E. WILLIAMS

2. Date of Death  
Month Day Year

February 2, 1999

3. Time of Death

8:30 A.M.

4a. Facility Name (If not institution, give street and number)

Randolph Hills Nursing Center

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

5. Social Security Number

579-24-3710

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
3/9/11

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Cabin John

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

# 13 Carver Road

10f. Zip Code

20818

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Care Giver

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Walter T. Coates, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marie Spriggs

19a. Informant's Name/Relationship (Type, Print)

Shannon Steward/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as # 10 above

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Mem. Park 2/6/99

Date

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

Lany H. Pratt

22. Name and Address of Facility

H.S. Washington & Sons Co., Inc.  
4925 Burroughs Ave., N.E., Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic cancer  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Barry Rosenbaum

29c. License number

DO 9834

29d. Date signed (Month, Day, Year)

2/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARRY ROSENBAUM 3720 FARRAGUT AVE. KENSINGTON, MD 20895

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

B. Rosenbaum

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04842

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rome Darnell Witcher

2. Date of Death

Month

Day

Year

JANUARY 28 1999

3. Time of Death

11:00 A.M.

4e. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

208-48-5132

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

22 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 5, 1976

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

738 Capitol Heights Blvd.

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

None Never worked

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Corey K. Witcher

18. Mother's Name (First, Middle, Maiden Surname)

Shirley E. Bolton

19a. Informant's Name/Relationship (Type, Print)

Shirley B. Witcher/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

738 Capitol Heights Blvd. Capitol Heights, MD 20743

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Hills Cemetery Feb. 1, 1999 Clinton, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Cedar Hill Funeral Home, Inc.

4111 Pennsylvania Ave. Suitland, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cachexia

Approximate Interval Between Onset and Death

8-10 weeks

a. Due to (or as a consequence of):

Inflammatory Bowel disease

months

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

mental retardation

electrolyte imbalance

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

L. S. S. MD

29c. License number

D 053411

29d. Date signed (Month, Day, Year)

January 29<sup>th</sup> 99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J C Shestadi, 3060 mitchellville Rd #103, Bowie, MD, 20716

31. Date filed (Month, Day, Year)

FEB 04 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04843

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LUCILLE CARTER WHEATLEY</b>				2. Date of Death Month Day Year <b>January 30 1999</b>		3. Time of Death <b>2:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>531 Randolph Road, Apt #333-A</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>166-24-8835</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>January 1, 1926</b>	
	9. Birthplace (State or Foreign Country) <b>Pittsburg, PA</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
Usual Residence of Decedent								
10a. State <b>Maryland</b>			10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Silver Spring</b>		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number <b>531 Randolph Road, Apt #333-A</b>			10f. Zip Code <b>20904</b>		
10g. Citizen of What Country? <b>U.S.A.</b>			11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4+</b> Collage (1-4 or 5+) <b>4+</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Marketing Support Representative</b>			16b. Kind of Business/Industry <b>Private</b>			17. Father's Name (First, Middle, Last) <b>Charles Carter</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Chambers</b>			19a. Informant's Name/Relationship (Type, Print) <b>Marshall Wheatley/Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>810 L Street, NE, Washington, D.C. 20002</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>			20c. Location - City or Town, State <b>Brentwood, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Nancy A. Perentis</b>			22. Name and Address of Facility <b>J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>PANCREATIC Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>3 1/2 years</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day, Year) <b>January 30, 1999</b>								
28b. Time of Injury <b>M</b>								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Robert T. Dible M.D.</b>								
29c. License number <b>D0003396</b>								
29d. Date signed (Month, Day, Year) <b>January 30, 1999</b>								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Robert T. Dible, M.D., 106 Irving Street, N.W. #4200, Washington, D.C. 20010</b>								
31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>								
32. Registrar's Signature <b>[Signature]</b>								

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

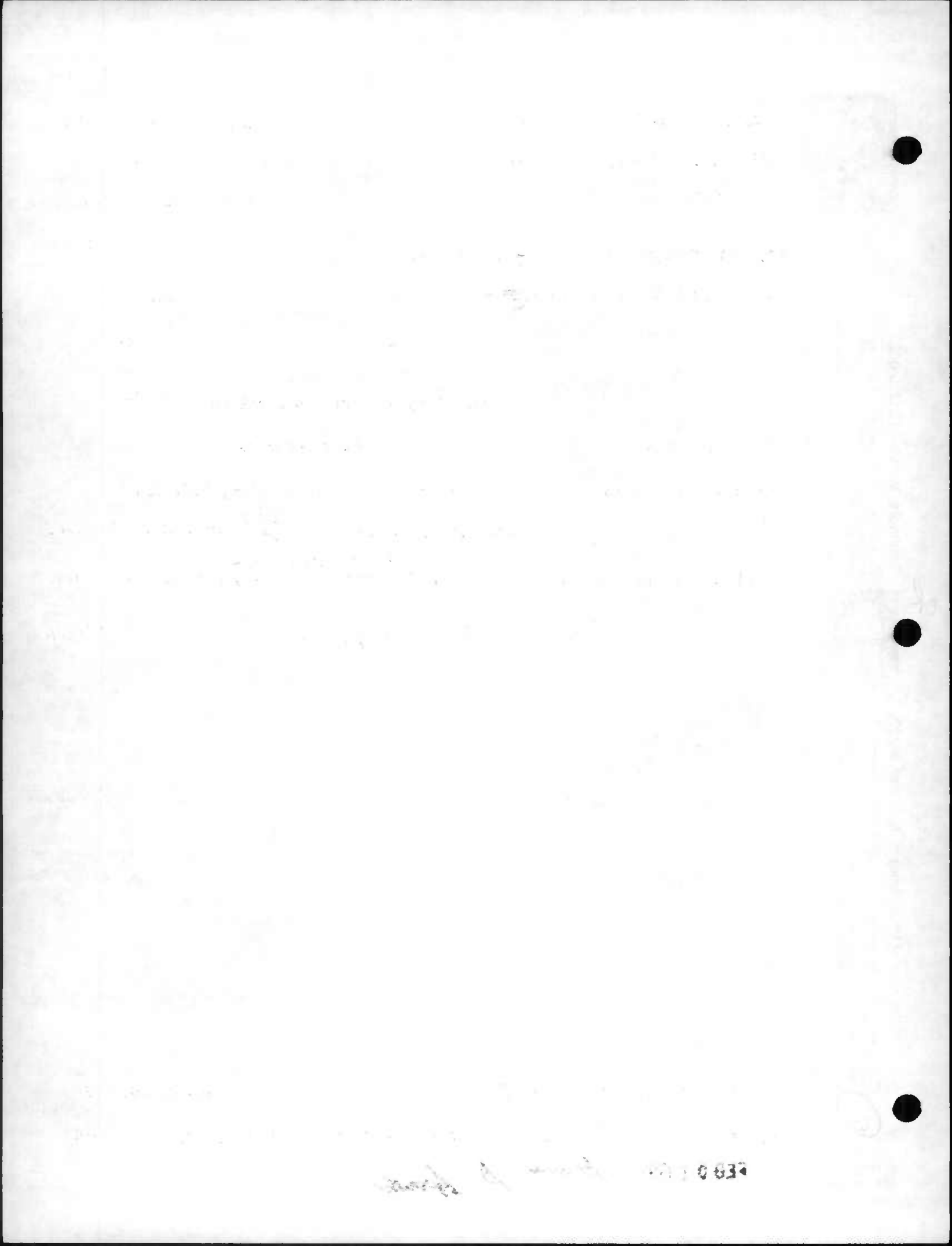
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04844

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jarvis Watson

2. Date of Death

January 28 1999 12:00 PM

3. Time of Death

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Doctors Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

370-32-7668

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 27, 1935

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

District Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1221 Edenville Dr.

10f. Zip Code

20747

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Maintenance

17. Father's Name (First, Middle, Last)

Jarvis Watson

18. Mother's Name (First, Middle, Maiden Surname)

Alzenia Dorsey

19e. Informant's Name/Relationship (Type, Print)

Mary A. Watson - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1221 Edenville Dr., District Heights, MD 20747

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee's Crematory

Date

2/3/99

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

John T. Stewart, III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary disease

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d. Hypertension

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D35947

29d. Date signed (Month, Day, Year)

1/29/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NORRIS MURPHY 10220 CORO ARLSON WAY #202 MITCHELLVILLE MD.

31. Date filed (Month, Day, Year)

FEB 02 1999

Registrar's Signature

[Signature]

State  
Registrar

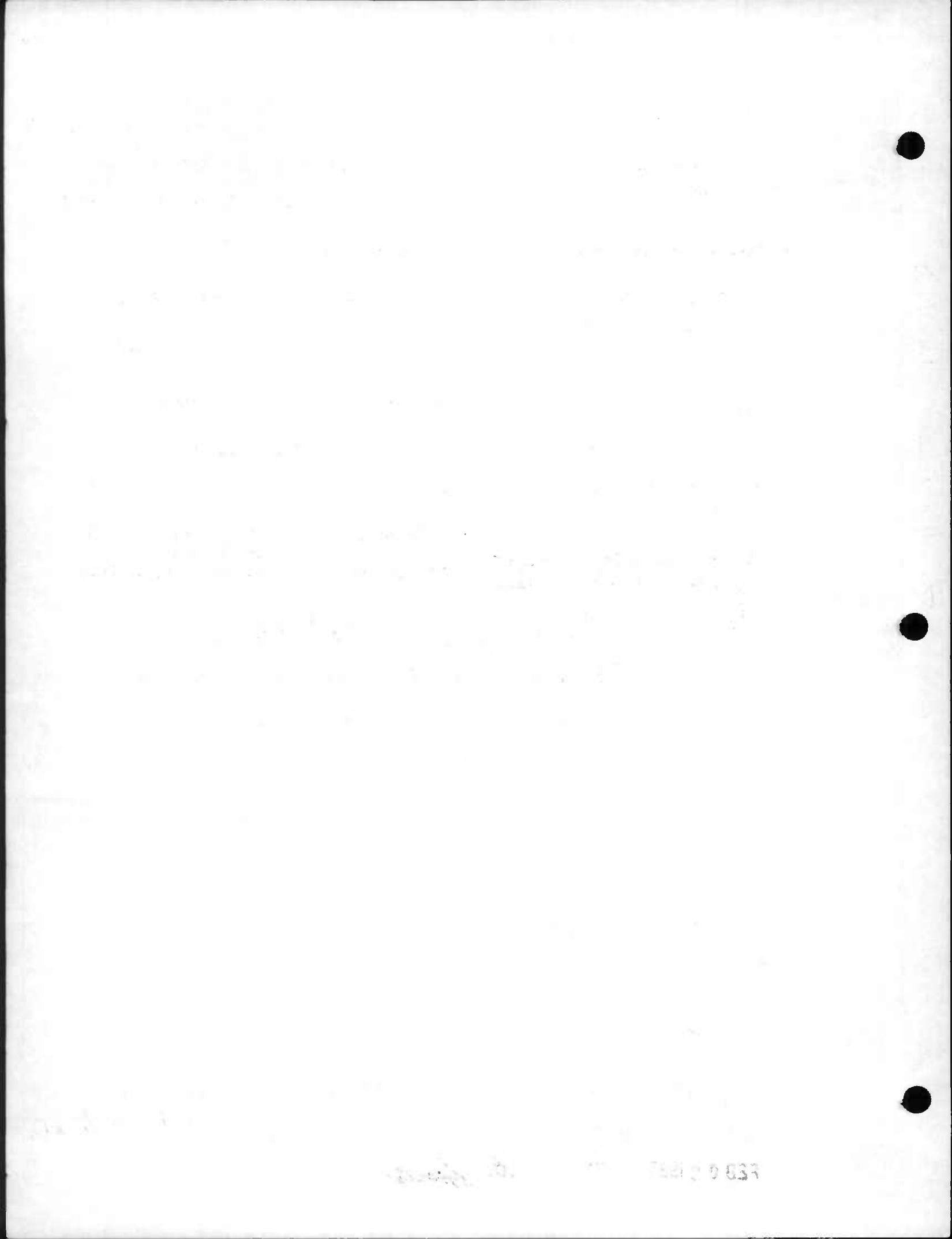
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-d show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04845

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIZABETH H. WATHEN</b>				2. Date of Death Month Day Year <b>JANUARY 18, 1999</b>		3. Time of Death <b>0200</b>		
	4a. Facility Name (If not institution, give street and number) <b>PINEVIEW NURSING HOME</b>				4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGES</b>		
Funeral Director	5. Social Security Number <b>172-03-0632</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APRIL 13, 1913</b>	9. Birthplace (State or Foreign Country) <b>JOHNSTOWN, PA</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Suitland</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>1920 LAKEWOOD ST.</b>				10f. Zip Code <b>20746</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>4 YRS.</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ADMINISTRATIVE ASSISTANT</b>		16b. Kind of Business/Industry <b>PRIVATE INDUSTRY</b>			
17. Father's Name (First, Middle, Last) <b>HORACE R. HINCHMAN</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>META PAUL</b>				
19a. Informant's Name/Relationship (Type, Print) <b>KARA ERWIN/ FRIEND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1920 LAKEWOOD ST. SUITLAND, MARYLAND 20746</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CEDAR HILL CEMETERY</b>		Date <b>1-21-99</b>		20c. Location - City or Town, State <b>SUITLAND, MARYLAND</b>		
21. Signature of Funeral Service Licensee <i>Juanara R. Braxton</i>				22. Name and Address of Facility <b>MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND RD. SUITLAND, MD 20746</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEHYDRATION</b> <b>PNEUMONIA</b> <b>FRACTURE OF LEFT HIP</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>01-03-99</b>		28b. Time of Injury <b>0520 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>SUBJECT FELL</b>	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>NURSING HOME</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>9106 PINEVILLE LANE CLINTON MARYLAND</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> DME		29c. License number <b>D33954</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 31, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARIO F. GOLUE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>									
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature <i>[Signature]</i>							

To Be Completed by Funeral Director

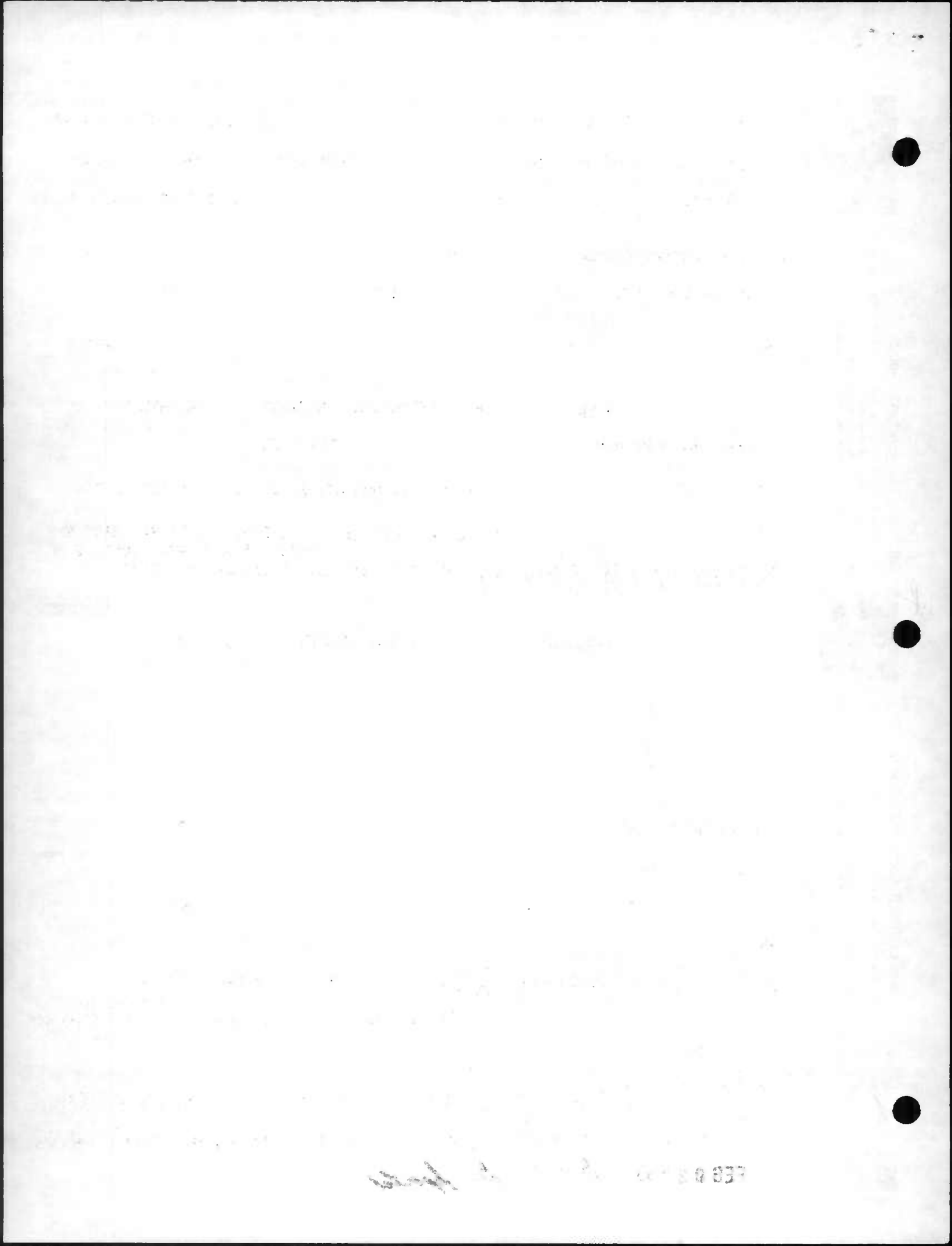
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



jhm  
CHARLES DARNELL  
WHITAKER

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04846

1. Decedent's Name (First, Middle, Last) <b>CHARLES DARNELL WHITAKER</b>		2. Date of Death Month <b>JANUARY</b> Day <b>29</b> , Year <b>1999</b>		3. Time of Death <b>16:41 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>10617 BROADLEAF DRIVE</b>		4b. City, Town, or Location of Death <b>Upper Marlboro</b>		4c. County of Death <b>PRINCE GEORGES</b>	
5. Social Security Number <b>239-92-8725</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>44</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>2-5-54</b>		9. Birthplace (State or Foreign Country) <b>Enfield, N.C.</b>			
10e. State <b>MD.</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Upper Marlboro</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10f. Zip Code <b>20774</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bus Operator</b>	
17. Father's Name (First, Middle, Last) <b>James A. Whitaker</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lara Mae Wilkins</b>		19. Kind of Business/Industry <b>N/A</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Brenda Whitaker-Silver/Sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10617 Broadleaf Dr., Upper Marlboro, Md. 20774</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Chapel Bapt. Ch. Cem.</b>		20c. Location - City or Town, State <b>2/6/99 Enfield, N.C.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Hackett's Funeral Chapel, Inc. 814- Upshur Street, N.W.</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <b>Atherosclerosis Cardiovascular disease</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>OCME</b>	
29d. Date signed (Month, Day, Year) <b>JANUARY 30, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>			
31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>		32. Registrar's Signature 			

**Baltimore, Maryland 21215-0020**

hemil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

## To Be Completed by Funeral Director

**Medical Certification: To Be Completed by Physician/Medical Examiner**





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 04847

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>CORRIE W WHITE</b>		2. Date of Death Month <b>01</b> - Day <b>27</b> - Year <b>99</b>		3. Time of Death <b>1:25AM</b>
4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>		4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince George's</b>
5. Social Security Number <b>577-50-1981</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <b>December 1937</b>		9. Birthplace (State or Foreign Country) <b>Ashville, S.C.</b>		
Usual Residence of Decedent				
10a. State <b>Md.</b>	10b. County <b>P.G.</b>	10c. City, Town or Location <b>Laurel</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>9023 Contee Rd,</b>		10f. Zip Code <b>20708</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Daycare Provider</b>		16b. Kind of Business/Industry <b>Self</b>		
17. Father's Name (First, Middle, Last) <b>Neal White</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lillie Mae Sanders</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Fanona N. Blackett (Niece)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5500 Karen Elaine Dr. New Carrollton Md. 20784</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Riverdale Crematory</b>		20c. Location - City or Town, State <b>2-2-99 Riverdale Md.</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Dunn &amp; Sons Funeral Service 5635 Eads St, N.E.</b>		

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>Cardiac Arrhythmia</b>		<b>Few min.</b>
Due to (or as a consequence of):		
<b>CHF</b>		<b>3-4 days</b>
Due to (or as a consequence of):		
Due to (or as a consequence of):		
Due to (or as a consequence of):		
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ischemic Cardiomyopathy</b> <b>Sepsis</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b> 28b. Time of Injury <b>1</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier M.D.		29c. License number <b>042580</b>	29d. Date signed (Month, Day, Year) <b>1-27-99</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PS AULLA MD 5638 Annapolis Rd #13 BLADENBURG MD 20710</b>			

State  
Registrar

31. Date filed (Month, Day, Year) <b>FEB 02 1999</b>	32. Registrar's Signature 
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04848

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERTA M. WILSON</b>				2. Date of Death Month Day Year <b>February 3, 1999</b>		3. Time of Death <b>3:05 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>215-26-9438</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar 16, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>NY</b>		10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>12907 Hoffmeister Ln NE</b>		10f. Zip Code <b>21502</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nursing Assistant</b>		16b. Kind of Business/Industry <b>Hospital</b>		
17. Father's Name (First, Middle, Last) <b>Robert A. Hoffmeister</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Mary E. (Rowan)</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Robert H. Wilson--son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12907 Hoffmeister Lane NE; Cumberland, MD 21502</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cumberland Crematory</b>		20c. Date <b>02/03</b>		20d. Location - City or Town, State <b>Cumberland, MD</b>		
21. Signature of Funeral Service Licensee <i>Scarpelli</i>				22. Name and Address of Facility <b>Scarpelli Funeral Home, P.A. Cumberland, MD 21502</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>5 DAYS</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Dr. V. Poonai</i>				29c. License number <b>D 36766</b>		29d. Date signed (Month, Day, Year) <b>February 3 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. V. Poonai, 920 National Highway, LaVale, MD 21502</b>								
31. Date filed (Month, Day, Year) <b>FEB 03 1999</b>				32. Registrar's Signature <i>D Sparks</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04849

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

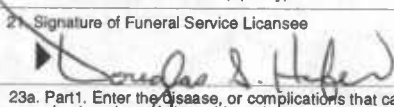
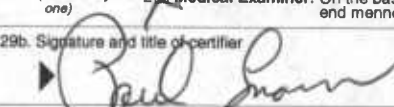

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>LOUISE FRANCES WARDEN</b>				2. Date of Death Month <b>FEB</b> Day <b>1</b> Year <b>1999</b>		3. Time of Death <b>9:19 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>12806 SANGSTON DR SW</b>				4b. City, Town, or Location of Death <b>LA VALE</b>		4c. County of Death <b>ALLEGANY</b>	
5. Social Security Number <b>475-30-4638</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV 18, 1934</b>	9. Birthplace (State or Foreign Country) <b>MINNESOTA</b>
Usual Residence of Decedent							
10a. State <b>MARYLAND ALLEGANY</b>		10b. County <b>LA VALE</b>		10c. City, Town or Location		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>12806 SANGSTON DR SW</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>		16b. Kind of Business/Industry <b>OWN HOME</b>	
17. Father's Name (First, Middle, Last) <b>MARVIN HANSEN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>AGNES IBLINGS</b>			
19a. Informant's Name/Relationship (Type, Print) <b>JAMES D. WARDEN/HUSBAND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12806 SANGSTON DR SW, LAVALE, MD 21502</b>			
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ROCKY GAP VETERANS CEMETERY</b>		20c. Location - City or Town, State <b>FLINTSTONE, MD</b>		20f. Date <b>FEB 4, 1999</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HAVER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. ARTERIOSCLEROTIC HEART DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>						Approximate Interval Between Onset and Death <b>UNKNOWN</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number <b>D09157</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 1, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. PAUL SNOW, 124 W 3RD ST., CUMBERLAND, MD 21502</b>							
31. Date filed (Month, Day, Year) <b>FEB 0 8 1999</b>				32. Registrar's Signature 			

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04850

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Martha Rebecca Williams

2. Date of Death  
Month Day Year  
January 27 19993. Time of Death  
10:15 p.m.

4a. Facility Name (If not Institution, give street and number)

Moran Manor Nursing Home

4b. City, Town, or Location of Death

Westernport

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

233-42-2706

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 6, 1905

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12 North Main Street, Apt. 201

10f. Zip Code

26726

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Elementary Education

17. Father's Name (First, Middle, Last)

Nathaniel Bruce

18. Mother's Name (First, Middle, Maiden Surname)

Estella Bruce

19a. Informant's Name/Relationship (Type, Print)

Lucille Stewart/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 2, Box 14 Burlington, WV 26710

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Hill Cemetery

Date

Jan. 31

1999

20c. Location - City or Town, State

Williamsport, WV

21. Signature of Funeral Service Licensee

Bryan L. Smith

22. Name and Address of Facility

Rotruck-Smith Funeral Home  
85 S. Main Street Keyser, WV 26726

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. END STAGE CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1/2 Hour

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accidental3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. Chang

29c. License number

D 25638

29d. Date signed (Month, Day, Year)

February 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.T. Chang, M.D. Frostburg Plaza Frostburg, MD 21532

31. Date filed (Month, Day, Year)

FEB 05 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04851

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Andrew Joseph Wyvill</u>				2. Date of Death Month <u>Feb.</u> Day <u>9</u> Year <u>1999</u>		3. Time of Death <u>1:35 am</u>												
	4a. Facility Name (If not institution, give street and number) <u>Southern Maryland Hospital</u>				4b. City, Town, or Location of Death <u>Clinton</u>		4c. County of Death <u>Prince George's</u>												
Funeral Director	5. Social Security Number <u>578-07-4046</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>85</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>June 25, 1913</u>												
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>Maryland</u>		10b. County <u>Prince George's</u>		10c. City, Town or Location <u>Upper Marlboro</u>												
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <u>14900 St. Thomas Church Road</u>		10f. Zip Code <u>20772</u>		10g. Citizen of What Country? <u>U.S.A.</u>													
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>													
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (14 or 5+) <u>2</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Editor/Publisher</u>		16b. Kind of Business/Industry <u>Enquirer - Gazette</u>															
17. Father's Name (First, Middle, Last) <u>Samuel A. Wyvill</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Barbara Schultz</u>															
19a. Informant's Name/Relationship (Type, Print) <u>Thomas A. Wyvill (Son)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>9106 Grandhaven Avenue Upper Marlboro, MD 20772</u>															
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Mount Carmel Cemetery</u>		20c. Location - City or Town, State <u>Upper Marlboro, Md</u>		20d. Date <u>Feb. 12, 1999</u>													
21. Signature of Funeral Service Licensed <u>[Signature]</u>				22. Name and Address of Facility <u>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735</u>															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>CARDIO RESPIRATORY ARREST</u></td> <td>2 HRS.</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <u>CONGESTIVE HEART FAILURE</u></td> <td>YRS</td> </tr> <tr> <td>c. <u>ISCHEMIC CARDIOMYOPATHY</u></td> <td>YRS</td> </tr> <tr> <td>d. <u>CORONARY ARTERY DISEASE</u></td> <td>YRS</td> </tr> <tr> <td colspan="2"></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <u>CARDIO RESPIRATORY ARREST</u>	2 HRS.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>CONGESTIVE HEART FAILURE</u>	YRS	c. <u>ISCHEMIC CARDIOMYOPATHY</u>	YRS	d. <u>CORONARY ARTERY DISEASE</u>	YRS		
Immediate Cause (Final disease or condition resulting in death)	a. <u>CARDIO RESPIRATORY ARREST</u>	2 HRS.																	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>CONGESTIVE HEART FAILURE</u>	YRS																	
	c. <u>ISCHEMIC CARDIOMYOPATHY</u>	YRS																	
	d. <u>CORONARY ARTERY DISEASE</u>	YRS																	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HYPERTENSION</u> <u>MITRAL REGURGITATION.</u>																			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier <u>G. Srinivasan</u>				29c. License number <u>D 46345</u>		29d. Date signed (Month, Day, Year) <u>02/08/1999</u>													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Gopalakrishnan Srinivasan, M.D. 8926 Woodyard Road, Suite 601, Clinton, Md 20735</u>																			
31. Date filed (Month, Day, Year) <u>FEB 09 1999</u>		32. Registrar's Signature <u>[Signature]</u>																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04852

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES ROLAND

WILSON

2. Date of Death  
Month Day Year  
FEBRUARY 2, 19993. Time of Death  
1125 a.m.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

578 22 3144

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

Oct 5, 1925

9. Birthplace (State or Foreign  
Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Dunkirk

10d. Inside City Limits  
☐ Yes ☒ No

10e. Street and Number

4103 Riverview Court

10f. Zip Code

20754

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?☒ Yes ☐ NoIf Yes, Give  
Year or Dates: 1943-4513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

telephone engineer

16b. Kind of Business/Industry

telephone

17. Father's Name (First, Middle, Last)

John Roland Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Lottie

Downs

19a. Informant's Name/Relationship (Type, Print)

Virginia D. Wilson / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as # 10 above

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MD Veterans Cemetery

Date

2-10-99

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

William R. Jones

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. PNEUMONIA / ADULT RESPIRATORY DISTRESS SYNDROME

Due to (or as a consequence of):

4-5 DAYS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. HYDROCEPHALUS / PRIOR PITUITARY TUMOR

Due to (or as a consequence of):

15 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending  
Investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

John H. Weigel, M.D.

29c. License number

226358

29d. Date signed (Month, Day, Year)

FEB. 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. John H. Weigel, M.D. 100 Hospital road Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

FEB 08 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
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To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



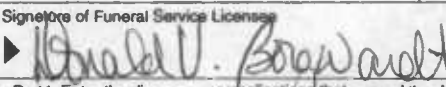


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04853

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ali Beigzadeh Youssefi</b>						2. Date of Death Month Day Year <b>Feb. 16, 1999</b>		3. Time of Death <b>3:45P.</b>																				
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>						4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>																				
Funeral Director	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 16, 1999</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>																				
	Usual Residence of Decedent																												
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Germantown</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																				
	10e. Street and Number <b>18646 Bayleaf Way</b>				10f. Zip Code <b>20874</b>		10g. Citizen of What Country? <b>United States</b>																						
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry																					
	17. Father's Name (First, Middle, Last) <b>Abtin Youssefi</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Leila Beigzadeh</b>																							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Abtin Youssefi (father)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>																							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD National Mem. Park</b>			Date <b>2/17/1999</b>		20c. Location - City or Town, State <b>Laurel, Maryland</b>																					
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>																							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																												
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>RESPIRATORY DISTRESS SYNDROME</b></td> <td><b>8 HRS</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td><b>EXTREME PREMATURITY</b></td> <td><b>8 HRS</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	<b>RESPIRATORY DISTRESS SYNDROME</b>	<b>8 HRS</b>	Due to (or as a consequence of):			b.	<b>EXTREME PREMATURITY</b>	<b>8 HRS</b>	Due to (or as a consequence of):			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.			d.	
Immediate Cause (Final disease or condition resulting in death)	a.	<b>RESPIRATORY DISTRESS SYNDROME</b>	<b>8 HRS</b>																										
	Due to (or as a consequence of):																												
	b.	<b>EXTREME PREMATURITY</b>	<b>8 HRS</b>																										
	Due to (or as a consequence of):																												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.																												
	d.																												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>INTRAVENTRICULAR HEMORRHAGE</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																					
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																					
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																													
29b. Signature and title of certifier 					29c. License number <b>D0053509</b>		29d. Date signed (Month, Day, Year) <b>2-16-99</b>																						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JANEL K. HINO, MD 1500 FOREST HLEN RD. SILVER SPRING, MD 20910</b>																													
31. Date filed (Month, Day, Year)		32. Registrar's Signature 																											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indeleible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04854

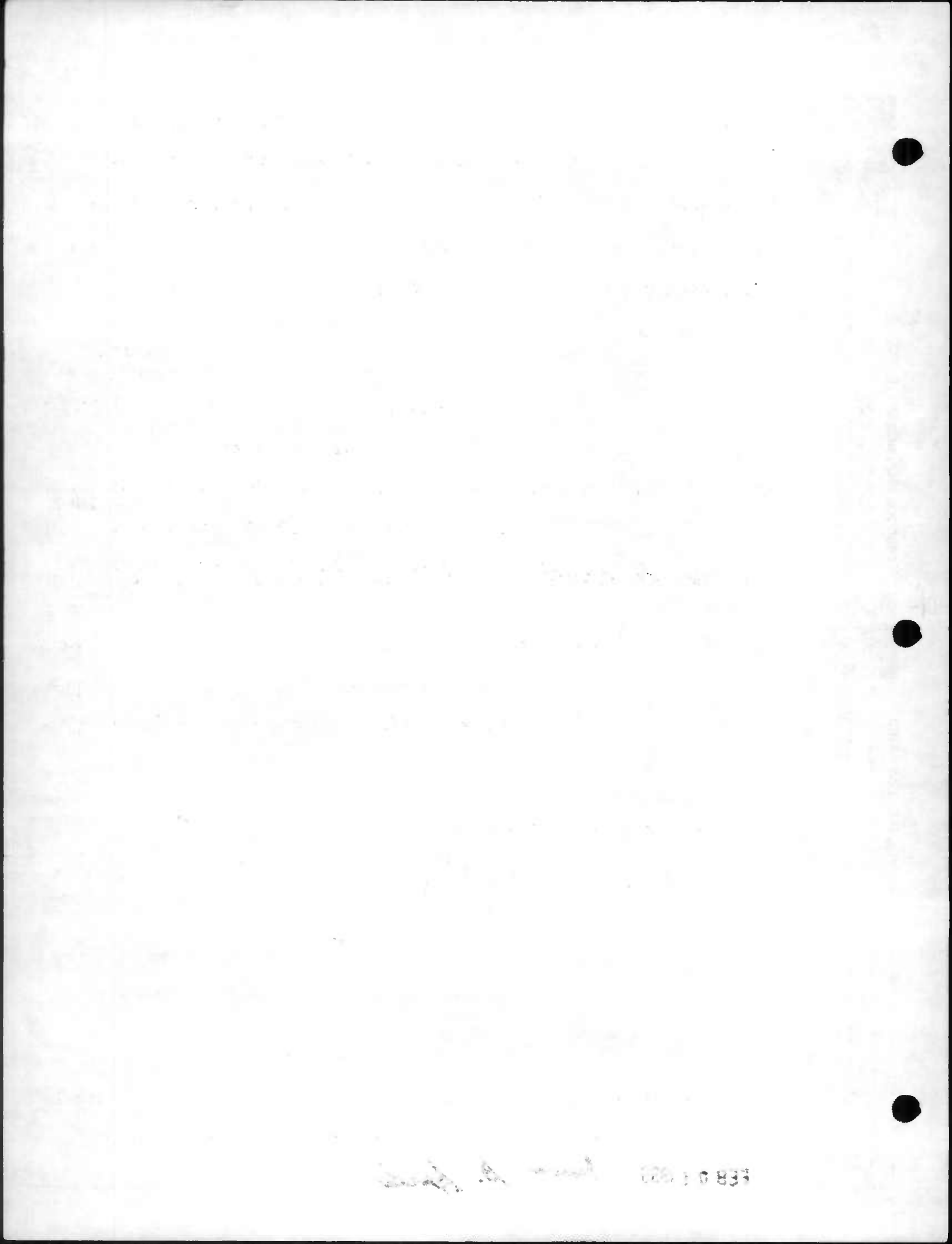
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Evelyn M. Zacharia</b>				2. Date of Death Month <b>January</b> Day <b>31</b> Year <b>1999</b>		3. Time of Death <b>3:50am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Montgomery Village Care and Rehab</b>				4b. City, Town, or Location of Death <b>Gaithersburg</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>577-24-2351</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 24, 1919</b>	
	9. Birthplace (State or Foreign Country) <b>Syria</b>		10a. State <b>Md.</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
Usual Residence of Decedent		10e. Street and Number <b>910 Venice Drive</b>		10f. Zip Code <b>20904</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>Schools</b>		16c. Kind of Business/Industry <b>Montgomery County</b>		
17. Father's Name (First, Middle, Last) <b>George Yazge</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Matilda Betar</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barbara J. Zamer/ Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10852 Game Preserve Rd. Gaithersburg, Md 20879</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glenwood Cemetery</b>		20c. Date <b>2/2/99</b>		20d. Location - City or Town, State <b>Wash. D.C.</b>		
21. Signature of Funeral Service Licensee <b>Philip D. Rinaldi</b>				22. Name and Address of Facility <b>Philip D. Rinaldi Funeral Service 11818 New Hampshire Ave. Silver Spring, Md</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Cor pulmonale</b> Due to (or as a consequence of):</p> <p>b. <b>Pulmonary hypertension</b> Due to (or as a consequence of):</p> <p>c. <b>CREST Syndrome (scleroderma variant)</b> Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death</p> <p><b>4 mos</b></p> <p><b>2 yrs</b></p> <p><b>10 yrs</b></p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>fracture right distal femur</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>2/1/99</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Alan Pollack M.D.</b>				29c. License number <b>D 33443</b>		29d. Date signed (Month, Day, Year) <b>February 1, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Alan Pollack M.D. 809 Viers Mill Rd. Rockville, Md 20850</b>								
31. Date filed (Month, Day, Year) <b>FEB 01 1999</b>		32. Registrar's Signature <b>[Signature]</b>						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04855

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George F. Armiger, Jr.				2. Date of Death Month Day Year February 14, 1999		3. Time of Death 7:23 a.m.														
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Rossville		4c. County of Death Baltimore Co.														
Funeral Director	5. Social Security Number 212-34-7349		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) 01-06-1936														
							9. Birthplace (State or Foreign Country) Maryland														
Usual Residence of Decedent																					
10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Rosedale			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
10e. Street and Number 1212 Berk Avenue				10f. Zip Code 21237		10g. Citizen of What Country? United States															
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1955-1958		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 Yrs.				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Asbestos Worker / Pipe Insulator			16b. Kind of Business/Industry Insulation														
17. Father's Name (First, Middle, Last) George F. Armiger, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Edna Seidenstricker																
19a. Informant's Name/Relationship (Type, Print) Mrs. Frances A. Armiger / Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 Berk Avenue Baltimore, Maryland 21237																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 2/18/99		20c. Location - City or Town, State Baltimore, Maryland														
21. Signature of Funeral Service Licensee Michael E. Canapp					22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td>RESPIRATORY FAILURE</td> <td>Approximate Interval Between Onset and Death 2-3 YEARS</td> </tr> <tr> <td>b.</td> <td>ASBESTOSIS, END-STAGE</td> <td>YEARS.</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	RESPIRATORY FAILURE	Approximate Interval Between Onset and Death 2-3 YEARS	b.	ASBESTOSIS, END-STAGE	YEARS.	c.			d.		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	RESPIRATORY FAILURE	Approximate Interval Between Onset and Death 2-3 YEARS																		
	b.	ASBESTOSIS, END-STAGE	YEARS.																		
	c.																				
	d.																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE CHRONIC OBSTRUCTIVE LUNG DISEASE							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown														
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No														
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)															
			28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and title of certifier					29c. License number D31076		29d. Date signed (Month, Day, Year) 2/15/99														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHRISTOPHER M.D., 6830 HOSPITAL DR., BALTIMORE, MD 21237																					
31. Date filed (Month, Day, Year) FEB 17 1999			32. Registrar's Signature B. Sparks																		

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 04856**  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jerome Adams Jr.</b>				2. Date of Death Month <b>FEB.</b> Day <b>14,</b> Year <b>1999</b>		3. Time of Death <b>1520 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>220-94-3142</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>22</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 26, 1976</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>1512 Edison Highway</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Food Service Processor</b>		16b. Kind of Business/Industry <b>Food Industry</b>		
17. Father's Name (First, Middle, Last) <b>Jerome Adams Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Carmalea Jones</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Carmalea J. Adams- mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>908 Ashbridge Drive, Essex, Maryland 21221 Apt. F</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Zion Cemetery</b>		20c. Location - City or Town, State <b>Feb. 19, 99 Lansdowne, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Caple Funeral Service 5502 Winner Ave. Baltimore, Maryland 21215</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex;"> <div style="flex: 1;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="flex: 2;"> <p>a. <b>Multi-system Organ Failure</b> Due to (or as a consequence of):</p> <p>b. <b>Acetaminophen and Alcohol ingestion</b> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) <b>UNK</b>		28b. Time of Injury <b>UNK</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>AT HOME</b>		28d. Describe how injury occurred <b>subject ingested large amount of acetaminophen</b>				
				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>908 Ashbridge Dr. Essex</b>				
29a. Certifier (check only) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>FEB. 16, 1999</b>		
29b. Signature and title of certifier 								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>J-LA for Lofgren 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04857

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Isabel Allen				2. Date of Death Month Day Year FEBRUARY 13, 1999		3. Time of Death 12:05 AM	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-05-8568		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 12, 1918	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 6129 Marglen Avenue				10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Baltimore County			
	17. Father's Name (First, Middle, Last) William Payson				18. Mother's Name (First, Middle, Maiden Surname) Anna Strunge			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kathy Allen				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6129 Marglenn Avenue Baltimore, Maryland 21206			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Cem.		Data 2/16/99		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee <i>Dorothy M. Blake</i>				22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Timothy J. Low M.D.</i>		29c. License number D-24034	
	29d. Date signed (Month, Day, Year) 2/13/99				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY J. LOW, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204			
	31. Date filed (Month, Day, Year) FEB 19 1999				32. Registrar's Signature <i>B. Sparks</i>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04858

Physician  
(Medical  
Examiner)Funeral  
Director

1. Decedent's Name (First, Middle, Last)

LAWRENCE ANZER

2. Date of Death

FEBRUARY 16 1999 10:15 a.m.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

212-01-3511

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

01/28/1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5919 Plumer Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Bank

17. Father's Name (First, Middle, Last)

John Anzer

18. Mother's Name (First, Middle, Maiden Surname)

Julie M. Fielder

19a. Informant's Name/Relationship (Type, Print)

Lawrence G. Anzer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5917 Plumer Avenue Baltimore, Maryland 21206

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Balto./Wash./Crematory

Date

2/19/99

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

John C. Miller Inc.

22. Name and Address of Facility

6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or head failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic Obstructive Pulmonary Disease

Approximate  
Interval Between  
Onset and Death

20 yrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

John C. Miller MD

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

FEBRUARY 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABIKI DUROJAYE 201 E. UNIVERSITY PKWY BALTIMORE, MARYLAND 21218

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

Benjamin S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04859

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rommye S. Bateman

2. Date of Death

February 17 1999 00:03

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital COLUMBIA

4b. City, Town, or Location of Death

4c. County of Death

HOWARD

Funeral  
Director

5. Social Security Number

238-60-2856

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
10/29/1904

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10e. State

MD

10b. County

HOWARD

10c. City, Town or Location

DAYTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5525 GREEN BRIDGE ROAD

10f. Zip Code

21036

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FARMER

16b. Kind of Business/Industry

FARMING

17. Father's Name (First, Middle, Last)

WARREN BATEMAN

18. Mother's Name (First, Middle, Maiden Surname)

ALICE ETHERIDGE

19e. Informant's Name/Relationship (Type, Print)

RAY E. BATEMAN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5525 GREEN BRIDGE ROAD DAYTON, MARYLAND 21036

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SOUND SIDE MISSIONARY BAPTIST CHURCH CEMETERY

Date

2/21/99

20c. Location - City or Town, State

COLUMBIA, NC

21. Signature of Funeral Service Licensee

M. Marshall

22. Name and Address of Facility

STERLING-ASHTON-SCHWAB FUNERAL HOME, INC.  
736 EDMONDSON AVE. CATONSVILLE, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

CHF

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HxN

cardiac arrhythmia s/p pacemaker

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Marshall

29c. License number

D0051958

29d. Date signed (Month, Day, Year)

February 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patient Medical Group Two Knoll North Drive COLUMBIA MD 21045

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04860

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna Pearl Brown						2. Date of Death Month Day Year February 16 1999		3. Time of Death 11:40 PM	
	4a. Facility Name (If not institution, give street and number) Mariner Health of Forest Hill						4b. City, Town, or Location of Death Forest Hill		4c. County of Death Harford	
Funeral Director	5. Social Security Number 214-22-7154	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) November 12, 1918		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD	10b. County Harford	10c. City, Town or Location Forest Hill				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1807 Ridgcroft Drive				10f. Zip Code 21050		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) George John Lachmann						18. Mother's Name (First, Middle, Maiden Surname) Susan Marie Walschmidt			
	19a. Informant's Name/Relationship (Type, Print) Susan B. Dorich				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Dellwood Drive Fallston, MD 21047					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Presbyterian Church		Date Feb. 20, 1999		20c. Location - City or Town, State Madonna, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Evans Funeral Chapel, P.A. 3 Newport Drive Forest Hill, Maryland 21050					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): Coronary artery disease  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death 1 day 75 yrs.	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier 		29c. License number D 32609		29d. Date signed (Month, Day, Year) 2/17/99			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kammam muidan ms. 703 Revolution St Hawkes Green ms 21078									
	31. Date filed (Month, Day, Year) FEB 19 1999		32. Registrar's Signature 							









Please Type or Print in Black Indelible Ink. Assure All Copies are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item:31 per V.R 2/19/99 reb

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILBERT H BRYANT JR.

2. Date of Death

FEB. 16 1999

3. Time of Death

3:30pm

4a. Facility Name (If not institution, give street and number)

1902 Middleborough Road

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-20-6807

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 22 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1902 Middleborough

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

8th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

Shipyard

17. Father's Name (First, Middle, Last)

Wilbert H. Bryant Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Dixon

19a. Informant's Name/Relationship (Type, Print)

Wayne S. Bryant / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6746 Danville Ave. Baltimore Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Moreland Memorial

Date

2/20/99

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex

300 Mace Ave. Baltimore Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. Acute Cardiogenic Shock

Due to (or as a consequence of):

c. Acute Myocardial Infarction

Due to (or as a consequence of):

d. Cardiac Arrhythmia.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M T O

29c. License number

D 21859

29d. Date signed (Month, Day, Year)

2/18/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAMMAD TAQI MD 6710 HOLABIRD AVEN BALT MD 21222

31. Date filed (Month, Day, Year)

218 FEB 19 1999

32. Registrar's Signature

Prave B. Apant

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04863

Item:20a per F.H G-768 2/19/99 reb

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM CARROL BROWN</b>						2. Date of Death Month <b>FEB</b> Day <b>17</b> Year <b>1999</b>		3. Time of Death <b>10:50 PM</b>				
	4a. Facility Name (If not institution, give street and number) <b>LEVINDALE GERIATRIC CENTER</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>				
Funeral Director	5. Social Security Number <b>215 03 3600</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs		8. Date of Birth (Month, Day, Year) <b>MAR. 24, 1914</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>				
	Usual Residence of Decedent												
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>3702 EDGEWOOD ROAD</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S. OF A.</b>							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>12/12/42 - 10/20/45</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>2 YEARS</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PAINTER</b>			16b. Kind of Business/Industry <b>MORGAN STATE UNIVERSITY</b>						
17. Father's Name (First, Middle, Last) <b>WILLIAM BROWN</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN JOHNSON</b>							
19a. Informant's Name/Relationship (Type, Print) <b>RUYH W. BROWN (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3702 EDGEWOOD ROAD BALTIMORE, MD. 21215</b>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>2/23/99</b> <b>GARRISON FOREST VET. CEM.</b>				20c. Location - City or Town, State <b>BALTO. OWINGS MILLS, MD. Co.</b>							
21. Signature of Funeral Service Licensee <b>Lewis T. Gwynn</b>				22. Name and Address of Facility <b>LEWIS T. GWYNN FUNERAL HOME 21215-6393</b> <b>4517 PARK HEIGHTS AVE. BALTO., MD.</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death. <b>CARCINOMA PROSTATE WITH METASTASES</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PARKINSON'S DISEASE, SENILE DEMENTIA</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>ATTENDING PHYSICIAN</b> <b>Dr. Gwynn</b>				29c. License number <b>D25610</b>		29d. Date signed (Month, Day, Year) <b>FEB. 18. 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SET HWAR M.D. 1 LEVINDALE 2434 WEST BELVERDERE AVENUE BALTIMORE MD</b>													
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>				32. Registrar's Signature <b>B. Spack</b> <b>21215</b>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





WRC  
99-0856-510  
POLY  
BLACKBURN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
ITEM: #23 PART I PER MEU G770 4-12-99 G768 2-24-99 WR.  
ITEMS: #23 PART I, II, 27, 28A-F PER MEU  
Certificate of Death

Reg. No.

99 04864

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Polly Rochelle Blackburn</b>				2. Date of Death Month Day Year <b>FEB. 15, 1999</b>		3. Time of Death <b>3:46 PM.</b>	
4a. Facility Name (If not institution, give street and number) <b>11 N. WASHINGTON ST.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>220-82-5573</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>39</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 9, 1960</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore City</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>11 North Washington Street</b>				10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 Years</b> College (1-4or 5+) <b>Homemaker</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Bennett M. Blackburn</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Zelda R. Falteseck</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Monica Reinsfelder/Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1312 Fawn Grove Road New Park, PA 17352</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gdns. 2/19/1999</b>		20c. Location - City or Town, State <b>Middle River, MD</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Duda- Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE NARCOTIC AND COCAINE INTOXICATION</b> <del>ACUTE NARCOTIC INTOXICATION</del>						Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) <b>a. Due to (or as a consequence of):</b>							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b>							
<b>c. Due to (or as a consequence of):</b>							
<b>d. Due to (or as a consequence of):</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PNEUMONIA</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Found: 2-15-99</b>		28b. Time of Injury <b>UNKNOWN</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred <b>UNKNOWN</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>11 N. WASHINGTON ST. BALTIMORE, MARYLAND</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>FEB. 16, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04865

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Earl Franklin Bruder				2. Date of Death Month Day Year February 16, 1999				3. Time of Death 8:40 AM	
	4a. Facility Name (If not institution, give street and number) Manor Care Nursing Center - Rossville				4b. City, Town, or Location of Death Rossville				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 194-07-3557		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 15, 1906		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 4257 Darleigh Road				10f. Zip Code 21236		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elevator Mechanic				16b. Kind of Business/Industry Elevator Company	
	17. Father's Name (First, Middle, Last) Charles Bruder				18. Mother's Name (First, Middle, Maiden Surname) Bertha Oldt					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Millicent Chernich (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4257 Darleigh Road, Baltimore, MD 21236					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery		20c. Location - City or Town, State Lebanon, PA					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Aortic Abdominal Aneurysm Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number 095475		29d. Date signed (Month, Day, Year) 2/20/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.L. KAHNAMA 17 FONTANA LN. BALTIMORE MD 21237										
31. Date filed (Month, Day, Year) FEB 19 1999		32. Registrar's Signature 								

ORIGINAL



99-0842-510  
IRVIN BROOKS  
ADH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04866

10F  
ITEMS: #10A, 10E, PER F.H. G768 2-19-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRVIN GAITHER BROOKS</b>						2. Date of Death Month Day Year <b>FEBRUARY 14, 1999</b>		3. Time of Death <b>1359 PM</b>						
	4a. Facility Name (If not institution, give street and number) <b>5906 PARK HEIGHTS AVENUE</b>						4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>						
Funeral Director	5. Social Security Number <b>219-28-4403</b>		6. Sex <b>10M 20F</b>		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUN. 25, 1931</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>CATONSVILLE BALTIMORE</b>				10d. Inside City Limits <b>10 Yes 20 No</b>						
	10e. Street and Number <b>5906 PARK HEIGHTS AVE.</b>				10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A</b>								
	11. Marital Status <b>30 Widowed 40 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>10 Yes 20 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>10 Yes 20 No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: BLACK</b>							
	15. Decedent's Education (Specify only highest grade completed) <b>12TH</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MAINTENANCE</b>			16b. Kind of Business/Industry <b>SCHOOL</b>							
	17. Father's Name (First, Middle, Last) <b>HERMAN P. BROOKS</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MARY MCINTYRE</b>								
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>ELIZABETH DURHAM - SISTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3417 SPRINGDALE AVE, BALT, MD, 21216</b>										
	20a. Method of Disposition <b>10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify)</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO</b>		20c. Location - City or Town, State <b>2-16-99 CATONSVILLE MD</b>		20d. Location - City or Town, State <b>2-16-99 CATONSVILLE MD</b>						
	21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and address of funeral home <b>GARY P. MARCA FUNERAL HOME P.A. 270 FRED HILTON PASS BALT, MD, 21229</b>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death				
	23b. Did tobacco use contribute to the cause of death? <b>10 Yes 20 No 30 Probably 40 Unknown</b>														
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <b>INSPECTION 10 Yes 20 No</b>										24b. Were autopsy findings available prior to completion of cause of death? <b>10 Yes 20 No</b>				
	25. Was case referred to medical examiner? <b>10 Yes 20 No</b>				26. Place of Death (Check only one) Hospital: <b>10 Inpatient 20 ER/Outpatient 30 DOA</b> Other: <b>40 Nursing Home 50 Residence 60 Other (Specify)</b>										
	27. Manner of Death <b>10 Natural 20 Accident 30 Suicide 40 Homicide</b> <b>50 Pending investigation 60 Could not be determined</b>				28a. Date of injury (Month, Day, Year) <b>M</b>		28b. Time of injury <b>M</b>		28c. Injury et Work? <b>10 Yes 20 No</b>		28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	29a. Certifier (Check only one) <b>10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>20 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>										29b. Signature and Title of certifier <b>[Signature]</b>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 15, 1999</b>
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201</b>														
	31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <b>[Signature]</b>												

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04867

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BERNADINE BOND</b>						2. Date of Death Month <b>February</b> Day <b>16</b> Year <b>1999</b>		3. Time of Death <b>1:40 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital Center</b>						4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>220-12-7297</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 6 1903</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>			10b. County <b>N/A</b>			10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4205 Elderon Avenue</b>						10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Homemaker</b>						16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Theodore Leighba Pierce</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Lillie Chapman</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Pierce / Niece</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4205 Elderon Avenue Baltimore, Maryland 21215</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Memorial Park</b>			Date <b>2-19-99</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Steven T. Butler</b>						22. Name and Address of Facility <b>Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, Maryland 21212</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CEREBRAL THROMBOSIS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA</b>										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier <b>Joginder P Mehta MD</b>		29c. License number <b>041410</b>		
29d. Date signed (Month, Day, Year) <b>February 16th, 1999</b>						29e. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Joginder P Mehta Northwest Hospital Center Randallstown</b>						31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				
32. Registrar's Signature <b>B. Sparks</b>						33. Registrar's Title <b>State Registrar</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04868

Item#11 perFHG768 2/24/99 EW

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thelma Doris Bullard

2. Date of Death  
Month Day Year

February 13 1999

3. Time of Death

6:00pm

4a. Facility Name (If not institution, give street and number)

Frederick Villa Nursing Home

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-18-9020

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 12, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6303 Rowe Court

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles M. Harris

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Katherine Murphy

19a. Informant's Name/Relationship (Type, Print)

Linda Bullard (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6303 Rowe Court, Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park Cemetery

Date

2/17/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Sharon J. McComack

22. Name and Address of Facility

Witzke Funeral Homes, Inc.  
1630 Edmondson Avenue, Catonsville, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Pneumonia  
Due to (or as a consequence of):

2 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Progressive Supranuclear Palsy  
Due to (or as a consequence of):

5 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Sharon J. McComack MD

29c. License number

038762

29d. Date signed (Month, Day, Year)

February 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sharon J. McComack MD  
5411 Old Frederick Rd. Baltimore, Md. 21229

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

Barbara B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

3. Time of Death  
9:00 a.m.Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John William Bartenfelder

2. Date of Death

February 13, 1999

Year

4a. Facility Name (If not institution, give street and number)

2113 Oakland Road

4b. City, Town, or Location of Death

Baltimore County

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-07-5919

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 8, 1912

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2113 Oakland Road

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8College (1-4 or 5+)  
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembly Man

16b. Kind of Business/Industry

Glenn L. Martin Co.

17. Father's Name (First, Middle, Last)

William F. Bartenfelder

18. Mother's Name (First, Middle, Maiden Surname)

Mary Unknown

19a. Informant's Name/Relationship (Type, Print)

Barbara Wilson (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1771 Pleasantville Road Forest Hill, Maryland 21050

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park February 17, 1999

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Boother Looson Chomoki

22. Name and Address of Facility

Lassan Funeral Home, Inc.

7401 Belair Road Baltimore, Maryland 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Adenocarcinoma of the lung  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 1/2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeffrey A. Cool MD

29c. License number

D34650

29d. Date signed (Month, Day, Year)

2-16-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JEFFREY A. COOL 9712 BELAIR RD BALTIMORE MD 21236

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04870

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Annie Belle Penny				2. Date of Death Month Day Year February 12, 1999				3. Time of Death 2:50 P.M.			
	4a. Facility Name (If not institution, give street and number) Holly Hill Manor, Inc.				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 214-22-4708		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85		8. Date of Birth (Month, Day, Year) May 20, 1913		9. Birthplace (State or Foreign Country) Morganton, N.C.			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 531 Stevenson Lane				10f. Zip Code 21286		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sewing Machine Operator			16b. Kind of Business/Industry Sanford Shirt Company				
	17. Father's Name (First, Middle, Last) Major A. Buff				18. Mother's Name (First, Middle, Maiden Surname) Mae Williams							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Shirley Hayes (Step Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3012 Putty Hill Ave. Baltimore, Maryland 21234							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Reisterstown Meth. Cem.		20c. Date February 16, 1999		20d. Location - City or Town, State Reisterstown, Maryland					
	21. Signature of Funeral Service Licensee <i>Robert Joseph Chiroch</i>				22. Name and Address of Facility Lassan Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death <i>Year</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. Signature and title of physician				29c. License number D-17041				29d. Date signed (Month, Day, Year) 15 Feb 1999				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Mark I. Leavey MD 1205 York Road #38 Lutherville MD 21093												
31. Date filed (Month, Day, Year) FEB 19 1999				32. Registrar's Signature <i>Benjamin R. [Signature]</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





WRC  
99-0860-510  
GERALDINE  
BROWN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

6769 3-11-99 WR

Certificate of Death

Reg. No.

99 04871

ITEMS: #23 PART I, II, 27, 28A-F PER MEO

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Geraldine Brown</i>				2. Date of Death Month Day Year <i>FEB. 15, 1999</i>		3. Time of Death <i>5:21 PM.</i>	
	4a. Facility Name (If not institution, give street and number) <i>1129 HARLEM AVE.</i>				4b. City, Town, or Location of Death <i>BALTIMORE</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>216-52-3720</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>48</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Apr. 25, 1950</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>BALTIMORE</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. Street and Number <i>1129 Harlem Ave</i>				10f. Zip Code <i>21217</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9th grade</i> College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Name</i>		
17. Father's Name (First, Middle, Last) <i>Robert Brown</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mathe Susie Footman</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Mathe S. Footman / Mother</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1129 Harlem Ave Baltimore, Md 21217</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>ARATUS Memorial Park 2/20/99 ARATUS, Maryland</i>		Date <i>2/20/99</i>		20c. Location - City or Town, State <i>Baltimore, Md 21215</i>		
21. Signature of Funeral Service Licensee <i>Gray Harris</i>				22. Name and Address of Facility <i>CHATHAM - Morris Funeral Home 3540 RAISTERSTOWN ROAD BALTIMORE, MD 21215</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								
a. <i>ACUTE SUBDURAL HEMATOMA</i> Due to (or as a consequence of):								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
<i>END-STAGE RENAL DISEASE</i>								
<i>CHRONIC NARCOTISM</i>								
<i>DEPRESSION</i>								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>Found: 2-15-99</i>		28b. Time of Injury <i>UNKNOWN M</i>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>UNKNOWN</i>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>UNKNOWN</i>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>UNKNOWN</i>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Dennis J. Chute MD</i>				29c. License number <i>O.C.M.E.</i>		29d. Date signed (Month, Day, Year) <i>FEB. 16, 1999</i>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</i>								
31. Date filed (Month, Day, Year) <i>FEB 19 1999</i>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04872

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Shuler Cofield</b>				2. Date of Death Month <b>02</b> Day <b>16</b> Year <b>99</b>		3. Time of Death <b>10:30 pm</b>	
4a. Facility Name (If not institution, give street and number) <b>Mariner Health of Mt. Clare</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>219-22-3304</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>97</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 16, 1901</b>	
9. Birthplace (State or Foreign Country) <b>South Carolina</b>							
Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			
10e. Street and Number <b>3204 Presbury St.</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>African American</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b>		College (13-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic Worker</b>		16b. Kind of Business/Industry <b>Private Family</b>	
17. Father's Name (First, Middle, Last) <b>Elias Gilmore</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hattie Gilmore</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Ms. Pernell Cofield (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>601 E. 41<sup>st</sup> St. Balto. Md. 21218</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland National</b>		Date <b>2/20/99</b>		20c. Location - City or Town, State <b>Laurel, Md.</b>	
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md.</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>pneumonia</b> Due to (or as a consequence of): b. <b>congestive heart failure</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>A. Mohr M.D.</b>				29c. License number <b>D27716</b>		29d. Date signed (Month, Day, Year) <b>2-17-99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>5411 Old Frederick Rd. Baltimore. MD. 21229.</b>							
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				Registrar's Signature <b>B. Sparks</b>			

State  
Registrar



jlm

LINDA SUE

CASTILLO

Item: 10e per F.H G-768 2/19/99 reb

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04873

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Linda Sue Castillo</b>				2. Date of Death Month Day Year <b>FEBRUARY 14, 1999</b>		3. Time of Death <b>23:03 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>1314 PONTAIC AVENUE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>216-78-8718</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>40</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APRIL 16, 1958</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>1305 Pontiac Ave Apt 1</b>				10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>warehouse</b>		
17. Father's Name (First, Middle, Last) <b>Gordon Schluderberg</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Flora Drowsky</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Flora Drowsky MOTHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7400 Village Rd Apt 7 Sykesville MD 21784</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>metro crematory</b>		Data <b>19 Feb 99</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		
21. Signature of Funeral Home Licensee <b>Kelly Gregory Fink</b>		22. Name and Address of Facility <b>Fink Funeral Home, PA. 426 Crain Hwy SW Glen Burnie MD 21061</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Blunt Force Injuries of Head, Multiple Stab and Cutting Wounds</b> Due to (or as a consequence of): b. <b>Stomach</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>2/14/99</b>		28b. Time of Injury <b>2:30 AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>home</b>				28d. Describe how injury occurred <b>subject struck, stabbed, cut and strangled</b>				
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1305 Pontiac Avenue Baltimore Maryland</b>				28g. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Theodore M. King MD</b>				29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 15, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature <b>B. Sparks</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Ellen H. Cage

2. Date of Death

February 14, 1999

3. Time of Death

6:55 P.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

BALTIMORE

5. Social Security Number

215-26-9220

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 16 1931

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State  
Md

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2430 Golupski Rd.

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
TypesCollege (1-4or 5+)  
-16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

seamstress

16b. Kind of Business/Industry

Sewing factory

17. Father's Name (First, Middle, Last)

Robert McKnight

18. Mother's Name (First, Middle, Maiden Surname)

Idella unknown

19a. Informant's Name/Relationship (Type, Print)

Dawn M. Cage - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

431 Nicoll Ave. Baltimore, Md 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park Cemetery

Date

Feb 18 1999

20c. Location - City or Town, State

Catonsville, Maryland

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

EVANS Funeral Chapel  
8800 Harford Rd. Baltimore, Md 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Adult Respiratory Distress Syndrome

Due to (or as a consequence of):

48 Hours

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Aspiration

Due to (or as a consequence of):

c. Acute Embolic Stroke

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Katherine Assadi, D.O.

29c. License number

R.D. 185744

29d. Date signed (Month, Day, Year)

February 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Katherine Assadi 9000 Franklin Square DR. BALTIMORE, Maryland 21237

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
card.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04875

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Julius Cromwell</b>				2. Date of Death Month <b>February</b> Day <b>17</b> Year <b>1999</b>		3. Time of Death <b>9:00 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Old Court Nursing Home</b>				4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>212-07-5235</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>96</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>January 23, 1903</b>		
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>5412 Old Court Rd</b>		10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary <b>10th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>laborer</b>		16b. Kind of Business/Industry <b>Construction</b>		17. Father's Name (First, Middle, Last) <b>unk.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>unk.</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Abbie Goldstein / social worker</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5412 Old Court Rd Baltimore, MD 21133</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Cemetery</b>		20c. Location - City or Town, State <b>Arbutus, MD</b>	
21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>Cary R March Funeral Home PA 20 Frohilton Pass Baltimore, MD 21229</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pharyngeal Carcinoma</b> Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23c. Approximate Interval Between Onset and Death <b>months</b>	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D32158</b>		29d. Date, signed (Month, Day, Year) <b>2/18/99</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jyotin Parikh, MD 821 N. Eutaw Street, suite 407, Baltimore, MD 21201.</b>	
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <b>[Signature]</b>		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04876  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNE MARIE CONLON

2. Date of Death

Month Day Year  
February 15 1999

3. Time of Death

5:15 am

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

015-18-6179

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
October 20, 1914

9. Birthplace (State or Foreign Country)

Rhode Island

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 Dulaney Valley Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Religious

16b. Kind of Business/Industry

Religious Order

17. Father's Name (First, Middle, Last)

William Conlon

18. Mother's Name (First, Middle, Maiden Surname)

Alice Warnock

19a. Informant's Name/Relationship (Type, Print)

Sr. Philomena Tisinger VHM

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1500 35th Street N.W. Washington D.C. 20007

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

New Cathedral Cemetery

Date

2/18/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mitchell-Wiedefeld Home Inc.

6500 York Road Baltimore, Maryland 21212

23e. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)e. *Myocardial infarction*  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. *Myocardial infarction*  
Due to (or as a consequence of):c. *Myocardial infarction*  
Due to (or as a consequence of):d. *Myocardial infarction*  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Respiratory shock*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

29c. License number

D 15504

29d. Date signed (Month, Day, Year)

2-15-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

*B. Sparks*State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: CONLON, ANNE MARIE

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04877

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eva M. Chapman

2. Date of Death  
Month Day Year  
FEBRUARY 18 19993. Time of Death  
7:35 A.M.

4a. Facility Name (If not institution, give street and number)

Stella Maris at Mercy Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director5. Social Security Number  
219-38-93556. Sex  
1 ☐ M ☒ F7. Age (In yrs. last birthday)  
51 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
Dec. 5, 19479. Birthplace (State or Foreign  
Country)  
MD

Usual Residence of Decedent

10e. State  
MD10b. County  
N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

201 Warren Avenue

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thurman E. Kell

18. Mother's Name (First, Middle, Maiden Summa)

Evangeline R. Morris

19a. Informant's Name/Relationship (Type, Print)

Tracy L. Bear / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1422 Clarkson Street, Baltimore Maryland 21230

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
Western Cemetery, February 20, 1999

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee Victor P. Doda, Jr.

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.

1501 East Fort Avenue, Baltimore Maryland 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Metastatic Lung Cancer  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1 year

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D40854

29d. Date signed (Month, Day, Year)

2/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Roseberg

301

St Paul Pl

Baltimore, MD

21202

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

P. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

04878

ITEM: #10B PER F.H. G768 2-19-99 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILMA COVINGTON				2. Date of Death Month Day Year FEBRUARY 18 1999		3. Time of Death 6:55 AM			
	4a. Facility Name (If not institution, give street and number) LORAN FRANKFORD				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA			
Funeral Director	5. Social Security Number 218-22-3981		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month/Day/Year) 6/13/24		9. Birthplace (State or Foreign Country) NC	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD	10b. County BALTIMORE	10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	10e. Street and Number 1611 E. 31ST STREET				10f. Zip Code 21218		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry Can Company				
	17. Father's Name (First, Middle, Last) Grady Gingles				18. Mother's Name (First, Middle, Maiden Surname) Martha Hopkins					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Phyllis Jenkins (niece)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5500 Wesley Ave Baltimore, MD 21207					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gingles Family Cemetery		20c. Location - City or Town, State 2/25/99 Gastonia, NC		20d. Date of Disposition 2/25/99			
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Albert P. Wylie Funeral Hm PA 638 N. Gilmore St. Baltimore, MD					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ADVANCED ALZHEIMERS DZ. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
Medical Certification: To Be Completed by Physician/Medical Examiner	23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTIPLE PRESSURE ULCERS, CERVICAL, ASCVD, CVA E (M) HEMIPARESIS, PVD, ANEMIA, DYSPHAGIA				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier [Signature] MD				29c. License number 041291		29d. Date signed (Month, Day, Year) 2/18/99			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JONATHAN GUTTER, MD. 21 CROSSROADS DR. #330 OWINGS MILLS 21117									
31. Date filed (Month, Day, Year) FEB 19 1999			32. Registrar's Signature [Signature]							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04879

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lena A. Cappellino</b>		2. Date of Death Month <b>FEBRUARY</b> Day <b>18</b> Year <b>1999</b>		3. Time of Death <b>02:55 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Saint Agnes Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>101-12-9884</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>98</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>September 14, 1900</b>		9. Birthplace (State or Foreign Country) <b>New York</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>
	10c. City, Town or Location <b>Glen Burnie</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>1716 Pleasantville Drive</b>		10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>U. S. A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>
	16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Rosario Giordino</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Filipina Palermo</b>
	19a. Informant's Name/Relationship (Type, Print) <b>Phyllis Lankford (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1716 Pleasantville Drive Glen Burnie, Maryland 21061</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Anthony's Cemetery</b>		20c. Location - City or Town, State <b>Dunkirk, New York</b>
	21. Signature of Funeral Service Licensee <i>Michael C. Saffron</i>		22. Name and Address of Facility <b>Singleton Funeral Home PA 1 Second Avenue S. W. Glen Burnie, MD 21061</b>		
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) <b>a. Long-term heart failure</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>years</b>
	<b>b. Mitral valve prolapse</b> Due to (or as a consequence of):				<b>years</b>
	<b>c. Coronary Artery Disease</b> Due to (or as a consequence of):				<b>years</b>
	<b>d. Angina</b>				<b>years</b>
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Paul Smith MD house officer</i>		29c. License number <b>P12590</b>		29d. Date signed (Month, Day, Year) <b>February 18, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Daniel Fehstein MD 900 Caton Avenue Baltimore City, Maryland 21229</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <i>[Signature]</i>		

NAME: LENA CAPPELLINO

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

**Physician  
/Medical  
Examiner**

**Funeral  
Director**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last) <b>PAUL M. CUBY</b>				2. Date of Death Month <b>2</b> Day <b>15</b> Year <b>99</b>		3. Time of Death <b>4:45P</b>															
4a. Facility Name (If not institution, give street and number) <b>Stella Maris Hospice</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>															
5. Social Security Number <b>214-26-6959</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 29, 1929 Maryland</b>															
Usual Residence of Decedent																					
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No															
10e. Street and Number <b>208 DIENER Place #201</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>USA</b>															
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Korean Conflict</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <b>Black</b>															
15. Decedent's Education (Specify only highest grade completed) <b>8th grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Welder</b>		16b. Kind of Business/Industry <b>Sparrows Point Ship Yard</b>															
17. Father's Name (First, Middle, Last) <b>Wilson Cuby, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gladys Brooks</b>																	
19a. Informant's Name/Relationship (Type, Print) <b>John Cuby / Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2608 N. Rolling Road Baltimore, Md 21244</b>																	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Barns in Forest Veterans Cemetery</b>		Date <b>2-22-99</b>		20c. Location - City or Town, State <b>Dwight's Mills, Md</b>															
21. Signature of Funeral Service Licensee <b>Berry Harris</b>				22. Name and Address of Facility <b>CHATMAN-HARRIS #1 5240 REISTERSTOWN RD BALTIMORE, MD 21215</b>																	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;">                     Immediate Cause (Final disease or condition resulting in death)                       Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last                 </td> <td style="width:70%; vertical-align: top;"> <table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td style="width:25%;"><b>LUNG CANCER</b></td> <td style="width:70%;">Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">b.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">d.</td> <td></td> <td></td> </tr> </table> </td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	<table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td style="width:25%;"><b>LUNG CANCER</b></td> <td style="width:70%;">Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">b.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">d.</td> <td></td> <td></td> </tr> </table>	a.	<b>LUNG CANCER</b>	Due to (or as a consequence of):	b.		Due to (or as a consequence of):	c.		Due to (or as a consequence of):	d.		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	<table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td style="width:25%;"><b>LUNG CANCER</b></td> <td style="width:70%;">Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">b.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">d.</td> <td></td> <td></td> </tr> </table>	a.	<b>LUNG CANCER</b>	Due to (or as a consequence of):	b.		Due to (or as a consequence of):	c.		Due to (or as a consequence of):	d.										
a.	<b>LUNG CANCER</b>	Due to (or as a consequence of):																			
b.		Due to (or as a consequence of):																			
c.		Due to (or as a consequence of):																			
d.																					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No															
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred																	
28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and Title of certifier <b>[Signature]</b>				29c. License number <b>D43725</b>		29d. Date signed (Month, Day, Year) <b>2/16/99</b>															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>																					
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature <b>[Signature]</b>																	

PAUL CUBY February 15, 1999 4:45 p.m.

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician  
/Medical  
Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

3

200

**State  
Registrar**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items 7,8 Per FH FilmG768 2-19-99 rja

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SALLY BELL CHERRY</b>				2. Date of Death Month <b>February</b> Day <b>14</b> Year <b>1999</b> 15 p.m.		3. Time of Death <b>15 p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Maryland General Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>U/A</b>	
Funeral Director	5. Social Security Number <b>245-14-9955</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>95</b> 85 Yrs.		8. Date of Birth 1913 Month <b>Oct</b> Day <b>27</b> Year <b>1913</b>	
	9. Birthplace (State or Foreign Country) <b>Carolina</b>		10a. State <b>Maryland</b>		10b. County <b>U/A</b>		10c. City, Town or Location <b>BAITIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4128 WEST CHESTER ROAD</b>		10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>24 YEARS</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>REGISTERED NURSE</b>		16b. Kind of Business/Industry <b>Self Employed</b>			
	17. Father's Name (First, Middle, Last) <b>RICHARD SATTERRWHITE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HANNAH LAWRENCE</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Clementine Smith / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4128 WEST CHESTER ROAD Baltimore Md 21216</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEMORIAL Park</b>		20c. Location - City or Town, State <b>2-17-99 Woodman, Md</b>		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Quay Harris</b>				22. Name and Address of Facility <b>5240 REISTERSTOWN ROAD CHATMAN - HOME BALTIMORE, Md 21215</b>			
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia</b> <b>Renal Failure</b>				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier <b>Swaminathan M.D.</b>		29c. License number <b>P12677</b>		29d. Date signed (Month, Day, Year) <b>2/14/99</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Jawahar Swaminathan M.D. c/o Maryland General Hospital</b>				31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>			
	32. Registrar's Signature <b>P. Ap...</b>				33. State Registrar			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04882

ITEM: #8 PER F.H. G768 2-19-99 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRMA E. COMEAU</b>				2. Date of Death Month <b>FEB</b> Day <b>17</b> Year <b>1999</b>		3. Time of Death <b>6:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>DULANEY TOWSON HEALTH CARE CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-14-9073</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 29 1916</b>	9. Birthplace (State or Foreign Country) <b>Md.</b>	
	Usual Residence of Decedent							
10a. State <b>Md</b>		10b. County <b>HARFORD</b>		10c. City, Town or Location <b>JARRETSVILLE, Md.</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3509 GLEN OAK DRIVE</b>				10f. Zip Code <b>21084</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (14 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>HOME</b>		
17. Father's Name (First, Middle, Last) <b>CHARLES CULLISON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET HAUG</b>				
19a. Informant's Name/Relationship (Type, Print) <b>MICHAEL E. COMEAU / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3509 GLEN OAK DR. JARRETSVILLE, Md 21084</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HIGHVIEW CEM.</b>		20c. Location - City or Town, State <b>2/22/99 HARFORD County</b>		20d. Date		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HARTLEY MILLER FUNERAL HOME, CHD - 7527 HARFORD Rd. BALTO Md. 21234</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS</b> Due to (or as a consequence of): <b>b. PNEUMONIA</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b> <b>CORONARY ARTERY DISEASE</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>047945</b>		29d. Date signed (Month, Day, Year) <b>February 18 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HARRIS ALCEEM 3007 E. Northorn Parkway Baltimore MD 21214</b>								
31. Date filed (Month, Day, Year) <b>FEB 18 1999</b>		32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04883

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Betty J. Dukes</u>				2. Date of Death Month <u>February</u> Day <u>14</u> Year <u>1999</u>		3. Time of Death <u>4:07 am</u>	
	4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Bayview Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death	
Funeral Director	5. Social Security Number <u>220-36-0778</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>58</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>01-01-41</u>	9. Birthplace (State or Foreign Country) <u>SC</u>
	Usual Residence of Decedent							
10a. State <u>MD</u>		10b. County <u>NA</u>		10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <u>1415 Stromery Way</u>				10f. Zip Code <u>21224</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10th Grade</u> College (1-4 or 5+) <u>NA</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Private Duty</u>		16b. Kind of Business/Industry <u>homes in other people</u>		
17. Father's Name (First, Middle, Last) <u>Unknown</u>					18. Mother's Name (First, Middle, Maiden Surname) <u>Mamie Blair</u>			
19a. Informant's Name/Relationship (Type, Print) <u>Gary Webb+Rosalind Webb</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>21224</u> <u>1207 Joplin Street Baltimore, Maryland</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Mt. Zion Cemetery</u>		Date <u>02-19-99</u>		20c. Location - City or Town, State <u>Lansdowne, MD.</u>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>Baltimore, Maryland 21202</u> <u>WM.C.MARCH FH 1101 E.North Avenue</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>Pneumonia</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <u>weeks</u>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Metastatic squamous cell cancer of neck</u> <u>Superior Vena Cava Syndrome</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Kelly Brogan MD</u>		29c. License number <u>98027</u>		29d. Date signed (Month, Day, Year) <u>February 14, 1999</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Kelly Brogan Johns Hopkins Bayview Medical Center Baltimore, MD 21224</u>								
31. Date filed (Month, Day, Year) <u>FEB 19 1999</u>		32. Registrar's Signature <u>B. Sparks</u>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VINCENT DIXON

2. Date of Death

Feb. 16, 1999

3. Time of Death

2:45 pm

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

212-30-4813

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JULY 22, 1933

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

763 EDGEWOOD ST.

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1952 to 1956

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

SOUTHERN STEEL

17. Father's Name (First, Middle, Last)

ARTHUR DIXON

18. Mother's Name (First, Middle, Maiden Surname)

MAGGIE DIXON

19a. Informant's Name/Relationship (Type, Print)

TWYLLA JONES ( NEICE )

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4147 MOUNTWOOD RD. APT 3 BALTO, MD. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CROWNSVILLE V.A. CEMETERY 2/22/99 CROWNSVILLE MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A.

1300 EUTAW PLACE BALTIMORE MD. 21217

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. septic shock

Due to (or as a consequence of):

b. multiple Decubitus ulcers (infected)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 YRS

Not known

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

recent myocardial infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D15698

29d. Date signed (Month, Day, Year)

Feb 16, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARCO GALICIA Jr. MD Bon Secours Hosp. tal, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04885

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GORDON</b>				2. Date of Death Month <b>February</b> Day <b>15</b> Year <b>1999</b>				3. Time of Death <b>7:20 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>224-12-7452</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 1 1917</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent									
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>618 North Woodward Drive</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>			16b. Kind of Business/Industry <b>Driver</b>			
17. Father's Name (First, Middle, Last) <b>Robert E. Delp</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Phina Sentor</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Ora Delp / wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>618 North Woodward Drive Baltimore Md. 21221</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>			Date <b>2/19/99</b>		20c. Location - City or Town, State <b>Rossville Md.</b>		
21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>					22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>a. ISCHEMIC BOWEL</b>										<b>3 DAYS</b>
Due to (or as a consequence of): <b>b. ATHEROSCLEROTIC VASCULAR DISEASE</b>										<b>10 YEARS</b>
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Due to (or as a consequence of): <b>c.</b>										
Due to (or as a consequence of): <b>d.</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CVA</b> <b>CARDIOMYOPATHY</b> <b>ASPIRATION PNEUMONIA</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>R. Terry Connelly</b>					29c. License number <b>D46360</b>		29d. Date signed (Month, Day, Year) <b>February 15, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER MICHAEL A. ANKROM MD 4940 EASTERN AVENUE, BALTIMORE, MD 21224</b>										
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>					32. Registrar's Signature <b>B. Sparks</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04886

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edwin Dunkin Dilworth

2. Date of Death

February 15, 1999

3. Time of Death

2:05am

4a. Facility Name (If not institution, give street and number)

Manor Care

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217-05-6752

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 9, 1910

9. Birthplace (State or Foreign Country)

Baltimore City, Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3023 Taylor Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Grave Digger

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Howard Dilworth

18. Mother's Name (First, Middle, Maiden Surname)

Ida Jane Bears

19a. Informant's Name/Relationship (Type, Print)

Virginia R. Dilworth (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3023 Taylor Avenue Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park February 18, 1999

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert Joseph Chiswick

22. Name and Address of Facility

Lassahn Funeral Home, Inc.

7401 Belair Road Baltimore, Maryland 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dehydration

Due to (or as a consequence of):

b. Malnutrition

Due to (or as a consequence of):

c. Atherosclerotic heart disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

> 30 Months  
> 30 Months  
> 30 Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

M

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Joseph Chiswick

29c. License number

D42736

29d. Date signed (Month, Day, Year)

2-16-99

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

AYMAN ARKAD MD. 7600 OYER DRIVE TOWSON, MD 21204

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

Sandra A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 302.6.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04887

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Meredith M. Evans

2. Date of Death

Feb 18 1999

3. Time of Death

6:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1323 Pleasant Valley Drive

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

216-16-6508

6. Sex

M

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 17 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1323 Pleasant Valley Drive

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1943-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

U.S. Postal

17. Father's Name (First, Middle, Last)

Charles Evans

18. Mother's Name (First, Middle, Maiden Surname)

Della Brown

19a. Informant's Name/Relationship (Type, Print)

Thelma Evans wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1323 Pleasant Valley Dr. Catonsville, Md.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

Woodlawn Cemetery

Date

Feb 22 1999

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

C. C. Dungan

21. Name and Address of Facility

Dungan's Funeral Service  
1701 McCulloch St. Baltimore, Md. 21217

23a. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiac Arrest

Approximate Interval Between Onset and Death

Due to (or as a consequence of):

End Stage chronic obstructive -

Due to (or as a consequence of):

pulmonary disease

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph D. Baughman, M.D.

29c. License number

D02053

29d. Date signed (Month, Day, Year)

2-18-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH DECKELBAUM, M.D. 3635 OLD COURT RD BALTO MD 21208

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

Barbara S. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



STANLEY ESTREMSKY

Please Type or Print in Black Indelible Ink. Assure All Copies are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

99 04888

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stanley F. Estremsky, Jr.				2. Date of Death Month Day Year FEBRUARY 14, 1999				3. Time of Death 05:30 am		
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON				4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 212-18-2946		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) May 28, 1922		9. Birthplace (State or Foreign Country) Baltimore City, Md.		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 521 Charles St. Ave.				10f. Zip Code 21204				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer				16b. Kind of Business/Industry Western Electric Co.			
17. Father's Name (First, Middle, Last) Stanley F. Estremsky Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Rogus							
19a. Informant's Name/Relationship (Type, Print) Mary B. Estremsky (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 521 Charles St. Ave. Towson, Md. 21204							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. February 16, 1999		Date February 16, 1999		20c. Location - City or Town, State Baltimore, Maryland				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Md. 21236-4625							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Pulmonary emphysema Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate carcinoma, metastatic  23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier  Steven H. Pearlman, M.D., 6701 N. Charles St., Baltimore MD 21204				29c. License number D30206		29d. Date signed (Month, Day, Year) 2/15/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven H. Pearlman, M.D., 6701 N. Charles St., Baltimore MD 21204				31. Date filed (Month, Day, Year) FEB 19 1999							
32. Registrar's Signature 				33. Registrar's Signature							





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State of Maryland / Department of Health and Mental Hygiene

Item:14 per F.H G-768 2/19/99 reb

Certificate of Death

Reg. No.

99 04889

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DORIS M. FORSYTHE</b>				2. Date of Death Month Day Year <b>FEB 16, 1999</b>		3. Time of Death <b>13:00</b>	
	4a. Facility Name (If not institution, give street and number) <b>HARFORD MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>HAVRE DE GRACE</b>		4c. County of Death <b>HARFORD</b>	
Funeral Director	5. Social Security Number <b>216-42-4876</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>53</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 26, 1945</b>	
	9. Birthplace (State or Foreign Country) <b>MD.</b>		10. Usual Residence of Decedent 10a. State <b>MD.</b> 10b. County <b>BALTIMORE</b> 10c. City, Town or Location <b>BALTIMORE</b> 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		11. Street and Number <b>600 A CHERRYCREST RD.</b>		12. Zip Code <b>21225</b>	
13. Merital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		14. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		15. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		16. Race - American Indian, Black, White, etc. <b>ASIATIC</b> Specify: <b>BLACK</b>		
17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TECHNICIAN</b>		19. Kind of Business/Industry <b>WESTERN ELECTRIC</b>		20. Father's Name (First, Middle, Last) <b>CLEO THORNTON</b>		
21. Mother's Name (First, Middle, Maiden Summa) <b>CALLIE THORNTON</b>		22. Informant's Name/Relationship (Type, Print) <b>BENJAMIN FORSYTHE (HUSBAND)</b>		23. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>600 A CHERRYCREST RD. BALTO, MD. 21225</b>		24. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
25. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEM PARK</b>		26. Date <b>2/20/99</b>		27. Location - City or Town, State <b>ARBUTUS MD.</b>		28. Signature of Funeral Service Licensee <i>[Signature]</i>		
29. Name and Address of Facility <b>ESTEP BROTHERS FUNERAL HOME P.A.</b>		30. Address <b>1300 EUTAW PLACE BALTO. MD. 21217</b>		31. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. <b>Cerebrovascular disease</b> Due to (or as a consequence of): b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		32. Approximate Interval Between Onset and Death <b>2 Days</b>		
33. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Hypertension</b>		34. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		35. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		36. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
37. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		38. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		39. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		40. Date of Injury (Month, Day, Year) <b>M</b>		
41. Time of Injury <b>M</b>		42. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		43. Describe how injury occurred		44. Location (Street and Number or Rural Route Number, City or Town, State)		
45. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner 2 <input type="checkbox"/> Certifying Physician		46. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		47. Signature and title of certifier <i>[Signature]</i>		48. License number <b>D28339</b>		
49. Date signed (Month, Day, Year) <b>February 17, 1999</b>		50. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Linda Freilich 101 E. Wheel Rd. Bel Air, MD 21015</b>		51. Data filed (Month, Day, Year) <b>FEB 19 1999</b>		52. Registrar's Signature <i>[Signature]</i>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 99 04890

ITEMS: #15, 17, 19A PER INFORMANT G770 4-26-99 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT CARSON FRASER, SR.</b>				2. Date of Death Month Day Year <b>FEBRUARY 15, 1999</b>		3. Time of Death <b>10:30 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>543 LAKEVIEW CIRCLE</b>				4b. City, Town, or Location of Death <b>SEVERNA PARK</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>252-22-1780</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APRIL 11, 1925</b>	9. Birthplace (State or Foreign Country) <b>NEW YORK</b>	
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>SEVERNA PARK</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>543 LAKEVIEW CIRCLE</b>				10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>EXECUTIVE</b>		16b. Kind of Business/Industry <b>NASA</b>		
17. Father's Name (First, Middle, Last) <b>IRVING ERVING THOMAS FRASER</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>ELIZABETH ARMSTRONG KENNEDY</b>				
19a. Informant's Name/Relationship (Type, Print) <b>CONSTANCE MORELL FRASER (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>543 LAKEVIEW CIR., SEVERNA PARK, MD 21146</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		20c. Location - City or Town, State <b>2/16 BALTIMORE, MD</b>				
21. Signature of Funeral Service Licensee <b>KELLY GREGORY FINK</b>				22. Name and Address of Facility <b>FINK FUNERAL HOME, P.A. 426 CRAIN HWY., S.W., GLEN BURNIE, MD 21061</b>				
23a. Part I: Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Acute myocardial infarction</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>1 hour</b>							Approximate Interval Between Onset and Death <b>1 hour</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>congestive heart failure</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>B. Sparks</b>		29c. License number <b>D 23624</b>		29d. Date signed (Month, Day, Year) <b>Feb 16, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Basim K. Khawaja MD 16005 Quain Hwy Ste 201 Glen Burnie, Md. 21061</b>								
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <b>B. Sparks</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 04891

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM J FRAILER SR</b>				2. Date of Death Month Day Year <b>FEBRUARY 16 1999</b>		3. Time of Death <b>8:25 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>217-125444</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN 8, 1922</b>		9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>AA Co.</b>	10c. City, Town or Location <b>Glen Burnie</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>1207 Kenwood Rd</b>			10f. Zip Code <b>21060</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>manager</b>			16b. Kind of Business/Industry <b>Westinghouse</b>		
	17. Father's Name (First, Middle, Last) <b>John Frailer</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Rose Schrot</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Elsie Frailer wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1207 Kenwood Rd GB MD 21060</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Reinterment from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		Data <b>18 FEB 99</b>		20c. Location - City or Town, State <b>Baltimore</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Pink Funeral Home Pa</b> <b>476 Crain Hwy SW GB MD 21061</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. RECURRENT NONSMALL CELL LUNG CANCER 2 YEARS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b> <b>CORONARY ARTERY DISEASE</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>D. Rogers, RESIDENT</b>		29c. License number <b>P 10640</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 16, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LIZY B. THOMAS, HARBOR HOSPITAL CENTER, BALTIMORE,</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04892

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SYLVIA JEAN FREDERICK</b>						2. Date of Death Month Day Year <b>FEB 17 99</b>		3. Time of Death <b>11:23PM</b>									
	4a. Facility Name (If not institution, give street and number) <b>2915 KIDDS SCHOOL HOUSE ROAD</b>						4b. City, Town, or Location of Death <b>PARKTON</b>		4c. County of Death <b>BALTIMORE</b>									
Funeral Director	5. Social Security Number <b>505-01-0864</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN 25, 1917</b>		9. Birthplace (State or Foreign Country) <b>NEBRASKA</b>									
	Usual Residence of Decedent																	
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PARKTON</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	10e. Street and Number <b>2915 KIDDS SCHOOL HOUSE ROAD</b>				10f. Zip Code <b>21120</b>		10g. Citizen of What Country? <b>U.S.A.</b>											
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		College (1-4or 5+) <b>+1</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>			16b. Kind of Business/Industry <b>STERLING CHEMICAL COMPANY</b>										
	17. Father's Name (First, Middle, Last) <b>EDWARD MACH</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>LIBBIE PRYBL</b>											
Physician /Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>LIBBIE GORLESKI</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2915 KIDDS SCHOOL HOUSE RD. PARKTON, MD. 21120</b>													
	20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EVANS FUNERAL CHAPEL BEL AIR - P.A.</b>				Date <b>FEB 13 1999</b>		20c. Location - City or Town, State <b>FOREST HILL, MD</b>									
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>EVANS FUNERAL CHAPEL 5800 HARFORD RD. PARKVILLE, MD. 21234</b>													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Acute respiratory failure</b> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <b>8 hrs.</b></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <b>COPD</b> Due to (or as a consequence of):</td> <td rowspan="4"><b>years</b></td> </tr> <tr> <td>c.  Due to (or as a consequence of):</td> </tr> <tr> <td>d.  Due to (or as a consequence of):</td> </tr> <tr> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. <b>Acute respiratory failure</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>8 hrs.</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>COPD</b> Due to (or as a consequence of):	<b>years</b>	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. <b>Acute respiratory failure</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>8 hrs.</b>																
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <b>COPD</b> Due to (or as a consequence of):	<b>years</b>																
	c. Due to (or as a consequence of):																	
	d. Due to (or as a consequence of):																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred										
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																		
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>101915 S</b>		29d. Date signed (Month, Day, Year) <b>FEB 18, 1999</b>												
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. MARK S. KAPLAN 16921 YORK RD. MONTICLO, MD. 21111</b>																		
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <i>[Signature]</i>																

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



1961-1962

1963-1964

1964-1965

1965-1966

1966-1967

1967-1968

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2005-2006

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2007-2008

2008-2009

2009-2010

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Grace E. Fanning				2. DATE OF DEATH MONTH DAY YEAR 02 12 1999		3. TIME OF DEATH 3:45 P.M.	
4. SOCIAL SECURITY NUMBER 207-01-6265		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 04-18-1911	
9a. FACILITY NAME (If not institution, give street and number) The Wesley Home				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Raspeburg		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5102 Hazelwood Ave.				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) +4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY New Jersey Schools			
17. FATHER'S NAME (First, Middle, Last) Howard McCormack				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mable Reidenbach			
19a. INFORMANT'S NAME (Type/Print) Darlene Rehak/Niece				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5102 Hazelwood Ave. Baltimore, MD 21206			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore Washington Crema 2-14		20c. LOCATION — City or Town, State Laurel, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. K. Marshall				22. NAME AND ADDRESS OF FACILITY Sterling-Ashton-Schwab Funeral Home Inc. 736 Edmondson Ave. Catonsville, Md 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. MIDDLE CEREBRAL ARTERY THROMBOSIS DUE TO (OR AS A CONSEQUENCE OF):					Approximate interval Between Onset and Death 2 WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. HYPERTENSIVE CEREBROVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF):					YEARS
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Robert E. Roby, M.D.		29c. LICENSE NUMBER D-19425		29d. DATE SIGNED (Month, Day, Year) 12/13/99	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT E. ROBY, M.D. 2211 W. ROGERS AVE BALD, MD 21215							
31. DATE FILED (Month, Day, Year) FEB 19 1999		32. REGISTRAR'S SIGNATURE P. A. Sparks					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

X

X

Teacher

New

Maple Reidenbach

5102 Hazelwood Ave. Baltimore, MD 21206

Baltimore Washington Crematorium 14 Laurel, MD

Sterling-Ashton-Schwab Funeral Home Inc.  
736 Edmondson Ave. Catonsville, Md 21228

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04894

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE M. FULLER				2. Date of Death Month Day Year February 17, 1999				3. Time of Death 11 AM	
	4a. Facility Name (If not institution, give street and number) CATON MANOR GENESIS ELDER CARE				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-07-0644		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) 10/26/1908		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County BALTIMORE		10c. City, Town or Location HALETHORPE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1722 WINANS AVE.				10f. Zip Code 21227		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHIEF INSPECTOR			16b. Kind of Business/Industry MTA (BALTIMORE TRANSIT)		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) DAVID FULLER				18. Mother's Name (First, Middle, Maiden Surname) ELSIE ROBERTS					
	19a. Informant's Name/Relationship (Type, Print) HELEN T. FULLER/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1722 WINANS AVE. BALTIMORE, MD 21227					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE-WASHINGTON CREMATORY		Date 2/19/99		20c. Location - City or Town, State LAUREL, MD			
	21. Signature of Funeral Service Licensee May K. Marshall				22. Name and Address of Facility STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Malnutrition and Dehydration Due to (or as a consequence of): b. Dysphagia Due to (or as a consequence of): c. Cerebrovascular Accident Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 10 Days 2 Years 2 Years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier W. W. M. Attending Doctor				29c. License number D21684		29d. Date signed (Month, Day, Year) 2.18.99			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C.V. CYRIAC M.D. 8109 RITCHIE HWY, PASADENA, MD 21122									
	31. Date filed (Month, Day, Year) FEB 19 1999				32. Registrar's Signature B. Sparks					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04895

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Judith A. Formwalt				2. Date of Death Month Day Year February 17, 1999				3. Time of Death 5:05 PM	
	4a. Facility Name (If not Institution, give street and number) 563 Jandon Court				4b. City, Town, or Location of Death Millersville				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 216-60-5671		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 27, 1951		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Millersville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 563 Jandon Court				10f. Zip Code 21108		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Hospital	
	17. Father's Name (First, Middle, Last) Melvin John Bertrand				18. Mother's Name (First, Middle, Maiden Surname) Audrey C. Rausch					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Robert G. Formwalt Jr./Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 563 Jandon Court Millersville, MD 21108					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Pk.		Date Feb. 22 1999		20c. Location - City or Town, State Glen Burnie, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. BREAST CANCER Due to (or as a consequence of):								Approximate Interval Between Onset and Death 3-4 yrs	
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
							24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 				29c. License number D27730		29d. Date signed (Month, Day, Year) 2/19/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Gary I. Cohen, M.D., 6565 N. Charles St., Towson, Maryland 21204										
31. Date filed (Month, Day, Year) FEB 19 1999		32. Registrar's Signature 								

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04896

Item#20b perFHG768 2/23/99EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Nicolau Fish				2. Date of Death Month Day Year February 17, 1999				3. Time of Death 1:00 PM		
	4a. Facility Name (If not institution, give street and number) Brightwood Center				4b. City, Town, or Location of Death Lutherville				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 216-28-4614		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 70		8. Date of Birth (Month, Day, Year) December 7, 1928		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 1004 Kenilworth Dr.				10f. Zip Code 21204				10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker				16b. Kind of Business/Industry own home			
17. Father's Name (First, Middle, Last) Anthony Fish					18. Mother's Name (First, Middle, Maiden Surname) Dorothy King						
19a. Informant's Name/Relationship (Type, Print) John Fish/son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 Kenilworth Dr. Towson, MD 21204						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem Gardens Loudon Park Cemetery		Date 2/22/99		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee John D. Mitchell II					22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, MD 21212						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Cerebral vascular Accident Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Diabetes Peripheral Vascular Disease								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Allen Hettelman				29c. License number D27569		29d. Date signed (Month, Day, Year) 2/17/99	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Allen Hettelman, M.D. 1838 Greene Tree Rd., Suite 300 Pikesville, MD 21208											
31. Date filed (Month, Day, Year) FEB 19 1999				32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <i>June I. Fitzberger</i>				2. Date of Death Month <i>February</i> Day <i>16</i> Year <i>1999</i>		3. Time of Death <i>4:30 am</i>	
4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Bayview Medical Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
5. Social Security Number <i>025-14-9331</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>74</i>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>June 16, 1924</i>	9. Birthplace (State or Foreign Country) <i>Massachusetts</i>
Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>3939 Roland Avenue Apt. 522</i>				10f. Zip Code <i>21211</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> Collage (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>	
17. Father's Name (First, Middle, Last) <i>Alderic Sylvester</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Viola M. Thompson</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Jean Haney Daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1608 Forest Hill Avenue, Baltimore, Maryland 21230</i>			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>Entombment</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Loudon Park Cemetery</i>		Date <i>2/19/99</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>	
21. Signature of Funeral Service Licensee <i>Lynn B. Henss</i>				22. Name and Address of Facility <i>Burgee-Henss Funeral Home, PA 21211 3631 Falls Road, Baltimore, Maryland</i>			
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Congestive heart failure</i> Due to (or as a consequence of): <i>b. Chronic Obstructive pulmonary disease</i> Due to (or as a consequence of): <i>c. Coronary artery disease</i> Due to (or as a consequence of): <i>d.</i>							
23b. Approximate Interval Between Onset and Death <i>2 weeks</i> <i>10 years</i> <i>10 years</i>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Neander, MD</i>				29c. License number <i>97010</i>		29d. Date signed (Month, Day, Year) <i>February 16, 1999</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>4940 Eastern Avenue, Baltimore, MD 21224</i>							
31. Date filed (Month, Day, Year) <i>FEB 19 1999</i>		32. Registrar's Signature <i>Geneva B. Sparks</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04898

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANK FULLANO, SR.

2. Date of Death

February 17 1999

Day Year

3. Time of Death

2:35 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Geriatric Center

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

214-24-9540

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 30 1926

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

BALTIMORE Md

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

940 S. LAKEWOOD AVE

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
9College (1-4 or 5+)  
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WHOLESALE

16b. Kind of Business/Industry

SELF

17. Father's Name (First, Middle, Last)

GENNARO FULLANO

18. Mother's Name (First, Middle, Maiden Surname)

MARIANNA PERRAGIE

19a. Informant's Name/Relationship (Type, Print)

JAMES FULLANO

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

313 MERRILLANE, FALLSTON Md 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLY REDEEMER

Date

2/19/99

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

Hartley Miller

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME, LTD  
7527 HARFORD Rd BALTO Md. 21234

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. NECROTIZING MYOPATHY

Due to (or as a consequence of):

8 MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY

MALNUTRITION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael A. Ankrom MD

29c. License number

D46360

29d. Date signed (Month, Day, Year)

February 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL A. ANKROM MD 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE MD 21224

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

Benita B. Sparks

21224

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04899

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA S. GUINN

2. Date of Death

February 15 1999 1040 A.M.

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

216-03-3108

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
07/10/1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

715 MAIDEN CHOICE LANE

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

EDMUND B. STEINRUCKEN

18. Mother's Name (First, Middle, Maiden Surname)

EMMA J. BAUMLER

19a. Informant's Name/Relationship (Type, Print)

DAVID B. STEINRUCKEN/NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5798 ELKRIDGE HTS. ROAD BALTIMORE, MD 21075

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

BALTIMORE-WASHINGTON

CREMATORY

Date

2/17/99

20c. Location - City or Town, State

LAUREL, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

STERLING-ASHTON-SCHWAB FUNERAL HOME, INC.

736 EDMONDSON AVE. CATONSVILLE, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. \_\_\_\_\_  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Physician3 ☐ Coroner4 ☐ Other (Specify)5 ☐ Other (Specify)6 ☐ Other (Specify)7 ☐ Other (Specify)8 ☐ Other (Specify)9 ☐ Other (Specify)10 ☐ Other (Specify)11 ☐ Other (Specify)12 ☐ Other (Specify)13 ☐ Other (Specify)14 ☐ Other (Specify)15 ☐ Other (Specify)16 ☐ Other (Specify)17 ☐ Other (Specify)18 ☐ Other (Specify)19 ☐ Other (Specify)20 ☐ Other (Specify)21 ☐ Other (Specify)22 ☐ Other (Specify)23 ☐ Other (Specify)24 ☐ Other (Specify)25 ☐ Other (Specify)26 ☐ Other (Specify)27 ☐ Other (Specify)28 ☐ Other (Specify)29 ☐ Other (Specify)30 ☐ Other (Specify)31 ☐ Other (Specify)32 ☐ Other (Specify)33 ☐ Other (Specify)34 ☐ Other (Specify)35 ☐ Other (Specify)36 ☐ Other (Specify)37 ☐ Other (Specify)38 ☐ Other (Specify)39 ☐ Other (Specify)40 ☐ Other (Specify)41 ☐ Other (Specify)42 ☐ Other (Specify)43 ☐ Other (Specify)44 ☐ Other (Specify)45 ☐ Other (Specify)46 ☐ Other (Specify)47 ☐ Other (Specify)48 ☐ Other (Specify)49 ☐ Other (Specify)50 ☐ Other (Specify)51 ☐ Other (Specify)52 ☐ Other (Specify)53 ☐ Other (Specify)54 ☐ Other (Specify)55 ☐ Other (Specify)56 ☐ Other (Specify)57 ☐ Other (Specify)58 ☐ Other (Specify)59 ☐ Other (Specify)60 ☐ Other (Specify)61 ☐ Other (Specify)62 ☐ Other (Specify)63 ☐ Other (Specify)64 ☐ Other (Specify)65 ☐ Other (Specify)66 ☐ Other (Specify)67 ☐ Other (Specify)68 ☐ Other (Specify)69 ☐ Other (Specify)70 ☐ Other (Specify)71 ☐ Other (Specify)72 ☐ Other (Specify)73 ☐ Other (Specify)74 ☐ Other (Specify)75 ☐ Other (Specify)76 ☐ Other (Specify)77 ☐ Other (Specify)78 ☐ Other (Specify)79 ☐ Other (Specify)80 ☐ Other (Specify)81 ☐ Other (Specify)82 ☐ Other (Specify)83 ☐ Other (Specify)84 ☐ Other (Specify)85 ☐ Other (Specify)86 ☐ Other (Specify)87 ☐ Other (Specify)88 ☐ Other (Specify)89 ☐ Other (Specify)90 ☐ Other (Specify)91 ☐ Other (Specify)92 ☐ Other (Specify)93 ☐ Other (Specify)94 ☐ Other (Specify)95 ☐ Other (Specify)96 ☐ Other (Specify)97 ☐ Other (Specify)98 ☐ Other (Specify)99 ☐ Other (Specify)100 ☐ Other (Specify)

29b. Signature and title of certifier

29c. License number

PO 10874

29d. Date signed (Month, Day, Year)

Feb, 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony R. Dot, MD 900 CATON AVE BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME GUINN, VIRGINIA S.  
Division of Vital Records, P.O. Box 68760,

12 RSD





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

99 04900

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Madeleine Greenspan</i>		2. Date of Death Month <i>02</i> Day <i>16</i> Year <i>99</i>		3. Time of Death <i>9:30 A</i>
	4a. Facility Name (If not institution, give street and number) <i>Annapolis Nursing Rehab</i>		4b. City, Town, or Location of Death <i>Annapolis</i>		4c. County of Death <i>Anne Arundel</i>
Funeral Director	5. Social Security Number <i>113-28-7732</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>62</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <i>10/20/1936</i>		9. Birthplace (State or Foreign Country) <i>NEW YORK</i>		
Usual Residence of Decedent					
10a. State <i>MD</i>		10b. County <i>ANNE ARUNDEL</i>		10c. City, Town or Location <i>ANNAPOLIS</i>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <i>900 VanBUREN STREET</i>			10f. Zip Code <i>21403</i>		10g. Citizen of What Country? <i>U.S.A.</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>5</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>TEACHER</i>		16b. Kind of Business/Industry <i>EDUCATION</i>
17. Father's Name (First, Middle, Last) <i>MATTHEW STEIN</i>			18. Mother's Name (First, Middle, Maiden Summa) <i>SYLVIA GREENBERG</i>		
19a. Informant's Name/Relationship (Type, Print) <i>NEAL GREENSPAN/SON</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>20 NICHOLAS AVENUE EAST ROCKAWAY, NY 11518</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MOUNT ZION CEMETERY</i>		Data <i>2/19/99</i>	20c. Location - City or Town, State <i>MASPETH, NY</i>
21. Signature of Funeral Service Licensee <i>Phyllis Harris</i>			22. Name and Address of Facility <i>STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <i>Alzheimer's disease</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):					Approximate Interval Between Onset and Death <i>5 years</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <i>M</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and Title of certifier <i>Phyllis Harris</i>		29c. License number <i>DS181</i>		29d. Date signed (Month, Day, Year) <i>2/16/99</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>1833 A Forest Drive Annapolis, MD 21401</i>					
31. Date filed (Month, Day, Year) <i>FEB 19 1999</i>		32. Registrar's Signature <i>Anne P. Sparks</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04901

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 24 hours after death.  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 24a are marked other than "yes", the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>ROSALIE GRILL</b>		2. Date of Death Month <b>FEB</b> Day <b>15</b> Year <b>1999</b>		3. Time of Death <b>10:40 AM</b>
4a. Facility Name (If not institution, give street and number) <b>CHURCH HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
5. Social Security Number <b>212-09-2078</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b>	8. Date of Birth (Month, Day, Year) <b>Jan. 5, 1916</b>	9. Birthplace (State or Foreign Country) <b>Md.</b>
10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>101 N. Bond Street</b>		
10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Book Keeper</b>		16b. Kind of Business/Industry <b>Dept. Store</b>		
17. Father's Name (First, Middle, Last) <b>Frank Grillo</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Philomena DePalota</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Patricia Croyle/Guardian</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>101 N. Bond St., Balto., Md. 21231</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cemt.</b>		20c. Location - City or Town, State <b>Balto., Md.</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Moran-Ashton-Dabrowski Funeral Home, Inc. 3000 E. Baltimore St. Balto., Md. 21224</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>ACUTE MASSIVE INTRACEREBRAL and SUBARACHNOID HEMMORHAGE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 		29c. License number <b>D16619</b>		29d. Date signed (Month, Day, Year) <b>FEB. 15, 1999</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A. VERGARA - SOARES 101 N. BOND ST. BALT. MD. 21231</b>				
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature 		

UNCLASSIFIED


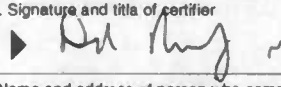

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04902

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>AMEDEO GABRIELE</b>				2. Date of Death Month Day Year <b>February 17, 1999</b>		3. Time of Death <b>9:05 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>STELLA MARIS of Mercy Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-16-9103</b>		6. Sex <b>M</b> <input checked="" type="checkbox"/> <b>F</b> <input type="checkbox"/>		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 20, 1920</b>	
	9. Birthplace (State or Foreign Country) <b>MD.</b>		10e. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore City</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>USA</b>		10h. Street and Number <b>209 S. EXETER ST.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (14 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FABRICATOR - STEEL</b>		16b. Kind of Business/Industry <b>STEEL MANUFACTURING</b>		17. Father's Name (First, Middle, Last) <b>BERNARDO GABRIELE</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>SANTA MARINELLI</b>		19a. Informant's Name/Relationship (Type, Print) <b>THERESA GABRIELE (WIFE)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>209 S. EXETER ST BALTO 21202 Md.</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Redeemer</b>		20c. Location - City or Town, State <b>BALTO. Md.</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>DELLA NOCERINO &amp; SONS FUNERAL HOME 322 S. HIGGINS ST. BALTO. 21202 Md.</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Aortic Myeloid Leukemia</b> Due to (or as a consequence of): <b>b. Myeloid Leukemia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>1 month</b> <b>3 years</b>		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) <b>STELLA MARIS AT MERCY</b> Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>2/17/99</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier 		29c. License number <b>D40854</b>		29d. Date signed (Month, Day, Year) <b>2/17/99</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Henry M. Roseberg 301 St Paul Pl Baltimore 21202</b>		
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature 		State Registrar		DHHM 16 Rev 6/95		

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04903

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arlene Raye Griffin						2. Date of Death Month Day Year February 16, 1999		3. Time of Death 1:05 A.M.	
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE Hospital Center						4b. City, Town, or Location of Death Rosedale		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 220-20-1437		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) 6/18/1929		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 7109 Greenwood Avenue						10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) XX 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meat Wrapper				16b. Kind of Business/Industry Grocery Store		
17. Father's Name (First, Middle, Last) William Middleditch						18. Mother's Name (First, Middle, Maiden Surname) Cleo Elizabeth Llewelyn				
19a. Informant's Name/Relationship (Type, Print) Yvonne Ryan						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7109 Greenwood Avenue Baltimore, Maryland 21206				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Red Brick Baptist Cem.		Date 2/18/99		20c. Location - City or Town, State Jarrettsville, MD.		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of): b. <u>Ischemic Bowels</u> Due to (or as a consequence of): c. <u>Volvulus</u> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 1 month
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Cachexia</u> <u>Urosepsis</u>								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number D37612		29d. Date signed (Month, Day, Year) February 16, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MOHAMAD ALABRASH 9000 FRANKLIN SQUARE DR. BALTIMORE, MARYLAND 21237										
31. Date filed (Month, Day, Year) FEB 19 1999				32. Registrar's Signature 						

Arlene Griffin

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



99-0798-510

99-032

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DAVID Item:18, per F.H G-769 3/9/99 reb  
GERTING ITEMS: 23 PART I, 27, 28A-F PER MEO G768

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04904

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>David William Gerting</b>				2. Date of Death Month Day Year <b>FEBRUARY 11, 1999</b>				3. Time of Death <b>7:27P.M.</b>					
4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death					
5. Social Security Number <b>217-56-8436</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>35</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>2/14/1963</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent													
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <b>1 Yes 2 No</b>					
10e. Street and Number <b>3722 Gibbons Avenue</b>				10f. Zip Code <b>21206</b>				10g. Citizen of What Country? <b>U.S.A.</b>					
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever In U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>				14. Race - American Indian, Black, White, etc. <b>Specify: White</b>					
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Computer Technician</b>				16b. Kind of Business/Industry <b>Unknown</b>					
17. Father's Name (First, Middle, Last) <b>William Grafton Gerting</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Carolyn A. Rawleigh</b>									
19a. Informant's Name/Relationship (Type, Print) <b>William Gerting</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3722 Gibbons Avenue Baltimore, Maryland 21206</b>									
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. Place of Disposition (Name of Cemetery, crematory or other place) <b>Balto./Wash. Crematory</b>				Date <b>2/18/99</b>		20c. Location - City or Town, State <b>Laurel, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>NARCOTIC INTOXICATION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>a. Due to (or as a consequence of):</b> <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>			
										24a. Was an autopsy performed? <b>1 Yes 2 No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>	
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>											
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year) <b>2-11-99</b>		28b. Time of Injury <b>UNKNOWN M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how Injury occurred <b>UNKNOWN</b>					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>UNKNOWN</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>4312 BERGER AVE. FOUND</b>							
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>													
29b. Signature and title of certifier 						29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 12, 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>													
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature 											

State  
Registrar



## Certificate of Death

Reg. No.

3. Time of Death

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HOLLIS ALLEN GRISWELL, JR.

2. Date of Death

FEBRUARY 12 1999

2:30 A

4a. Facility Name (If not institution, give street and number)

11406 SHERRIE LANE

4b. City, Town, or Location of Death

WHEATON

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

214-42-5873

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

01/08/1943

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

WHEATON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11406 SHERRIE LANE

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

UNEMPLOYED

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

HOLLIS ALLEN GRISWELL, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARY ANITA JAMES

19a. Informant's Name/Relationship (Type, Print)

NANCY G. APPLER/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5892 SELFORD ROAD BALTIMORE, MD 21227

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE-WASHINGTON  
CREMATORY

Date

2/19/99

20c. Location - City or Town, State

LAUREL, MD

21. Signature of Funeral Service Licensee

Phillip Stark

22. Name and Address of Facility

STERLING-ASHTON-SCHWAB FUNERAL HOME, INC.  
736 EDMONDSON AVE. CATONSVILLE, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Contact gunshot wound of the head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

Limited  
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

X ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

2-12-99

28b. Time of Injury

unknown M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State)

11406 Sherrrie Lane  
Montgomery County, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

FEBRUARY 12, 1999

30. Name and address of person who completed cause of death (Use 23a) (Type, Print)

Stephen S. Radentz

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 19 1999

Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

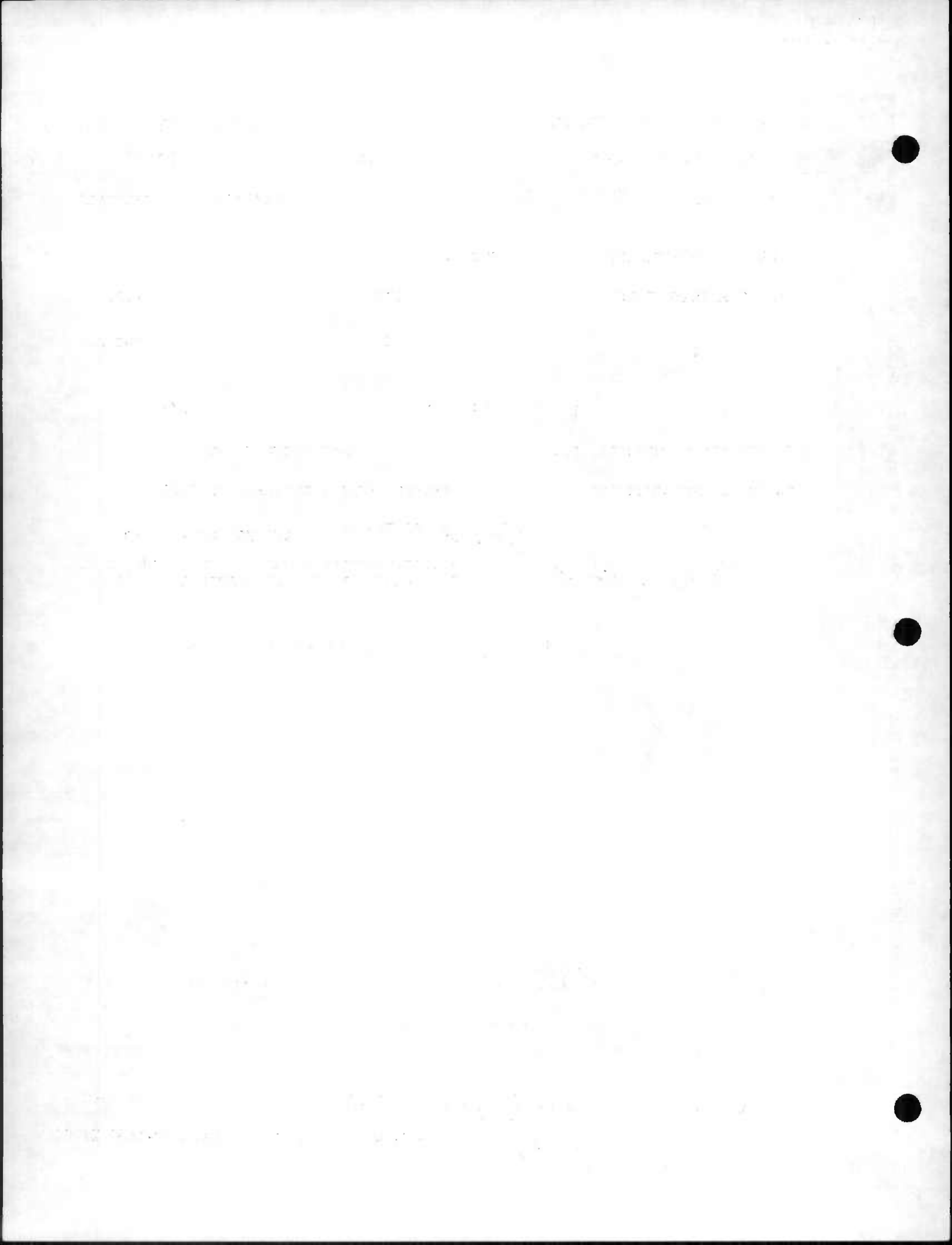
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04906

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY HAGGERTY

2. Date of Death  
Month Day Year

FEB 13 1999

3. Time of Death

10:00 PM

4a. Facility Name (If not institution, give street and number)

8800 WALTER BLVD. # 3312 WESTWOOD CT.

4b. City, Town, or Location of Death

PARKVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

219-64-4124

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

8. Under 1 Year

Months Days

9. Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN 2, 1920

9. Birthplace (State or Foreign Country)

ENGLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8800 WALTER BLVD. / WESTWOOD CT.

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOME MAKER

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

HAROLD VINCENT HOYLE

18. Mother's Name (First, Middle, Maiden Summa)

ANNIE HINDLE

19a. Informant's Name/Relationship (Type, Print)

KEITH RONALD, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14009 FOXLAND RD. PHOENIX, MD. 21131

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DIANEY VALLEY MEM. GONS.

Date

FEB. 17, 1999

20c. Location - City or Town, State

TIMONIUM, MD.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES

8800 HARFORD RD. PARKVILLE, MD. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *stroke*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *ASCVD*  
Due to (or as a consequence of):

c. *HTN*  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*hypercholesterolemia*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

044560

29d. Date signed (Month, Day, Year)

2/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10755 FALLS RD suite 460 LUTHERVILLE 21093

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

*[Signature]*

State Registrar

2020 TAY HAZEL BRY  
 Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04907

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE R. HOECK, SR.				2. Date of Death Month Day Year FEB. 16, 1999		3. Time of Death 1:50 AM	
	4a. Facility Name (If not institution, give street and number) GENESIS ELDER CARE - PERRING PKWY. CTR.				4b. City, Town, or Location of Death PARKVILLE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 213-10-4227		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) APRIL 22, 1910	
	9. Birthplace (State or Foreign Country) MD.		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location PARKVILLE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 7826 SHEPHERD AVE		10f. Zip Code 21234	
	10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PURCHASING AGENT		16b. Kind of Business/Industry BALTIMORE COUNTY	
	17. Father's Name (First, Middle, Last) JOSEPH H. HOECK				18. Mother's Name (First, Middle, Maiden Surname) KATHERINE M. PRELLER			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CLARA L. HOECK, SPOUSE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7826 SHEPHERD AVE PARKVILLE, MD. 21234			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EVANS FUNERAL CHAPEL - BEL AIR, P.A.		Date FEB. 17, 1999		20c. Location - City or Town, State FOREST HILL, MD.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 HARFORD RD. PARKVILLE, MD. 21234			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischemic Heart Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death years			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Liver Cirrhosis Chronic Obstructive Lung Disease Dementia				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D08378	
	29d. Date signed (Month, Day, Year) FEB. 17, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. GRACIO PATRICIO 8903 HARFORD RD. PARKVILLE, MD. 21234		31. Date filed (Month, Day, Year) FEB 19 1999		32. Registrar's Signature <i>[Signature]</i>	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04908

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **Alvirda E. Haas** 2. Date of Death Month **02** Day **14** Year **1999** 3. Time of Death **8:15am**

Funeral  
Director

4a. Facility Name (If not institution, give street and number) **8901 Old Frederick Rd.** 4b. City, Town, or Location of Death **Ellicott City** 4c. County of Death **Howard**

5. Social Security Number **212-07-8010** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **84** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **11-12-1914** 9. Birthplace (State or Foreign Country) **Ohio**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Howard** 10c. City, Town or Location **Ellicott City** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **8901 Old Frederick Rd.** 10f. Zip Code **21043** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **12 yrs.** Collage (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Homemaker** 16b. Kind of Business/Industry **Own Home**

17. Father's Name (First, Middle, Last) **Benjamin Crews** 18. Mother's Name (First, Middle, Maiden Surname) **Frances (Unknown)**

19a. Informant's Name/Relationship (Type, Print) **Robert Haas/ Husband** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **8901 Old Frederick Rd. Ellicott City, MD 21043**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Oakland Mills UMC Ceme.** Date **2/17/99** 20c. Location - City or Town, State **Sykesville, MD**

21. Signature of Funeral Service Licensee **[Signature]** 22. Name and Address of Facility **736 Edmondson Ave. Catonsville, MD 21228 Sterling-Ashton-Schwab Funeral Home Inc.**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death  
e. **Adenocarcinoma of uterus, metastatic months**  
Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **[Signature]** 29c. License number **D43195** 29d. Date signed (Month, Day, Year) **02, 15, 1999**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Stephen W George, MD** **4801 Dorsey Hall Dr. Suite 226, Ellicott City, MD 21042**

31. Date filed (Month, Day, Year) **FEB 19 1999** 32. Registrar's Signature **[Signature]**

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

99 04909

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ISAAC G. HINZMAN				2. Date of Death Month Day Year February 15, 1999				3. Time of Death 1:05 P.M.		
	4a. Facility Name (If not institution, give street and number) Memorial Hospital				4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany		
Funeral Director	5. Social Security Number 274-42-0396		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) 04/24/1946		9. Birthplace (State or Foreign Country) WV		
	Usual Residence of Decedent										
10a. State OH		10b. County CUYAHOGA		10c. City, Town or Location CLEVELAND				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 3418 EAST 70TH				10f. Zip Code 44127				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WELDER				16b. Kind of Business/Industry ALL ERECTION AND CRANE COMPANY			
17. Father's Name (First, Middle, Last) SHELBY HINZMAN					18. Mother's Name (First, Middle, Maiden Surname) MARJORIE BURDETTE						
19a. Informant's Name/Relationship (Type, Print) TERESA PARKER/DAUGHTER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8009 DORVER AVE. CLEVELAND, OH 44105						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) HILLCREST MEMORIAL PARK		Date 2/19/99		20c. Location - City or Town, State BEDFORD HTS., OH				
21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Hypertensive Cerebral Infarction</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) February 16, 1999			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>J. ALAN LOCKER, MD</i> 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) FEB 19 1999					32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04910

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>JAMES EDWARD HASSELL</b>				2. Date of Death Month Day Year <b>FEBRUARY 15, 1999</b>				3. Time of Death <b>8:00 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>813 S. GLOVER STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>	
5. Social Security Number <b>214-03-2685</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>7/18/20</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>813 S. GLOVER STREET</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>WAREHOUSE</b>			16b. Kind of Business/Industry <b>G.E.</b>		
17. Father's Name (First, Middle, Last) <b>WILLIAM HASSELL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JULIA J. GAMBELL</b>					
19a. Informant's Name/Relationship (Type, Print) <b>MRS. BETTY HASSELL</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>813 S. GLOVER ST. BALTIMORE, MD. 21224</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREEN MOUNT CEME.</b>		Date <b>2/17/99</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>			
21. Signature of Funeral Service Licensee <b>Charles Kaczorowski</b>				22. Name and Address of Facility <b>KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTIMORE, MD. 21224</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of): b. <b>Congestive Heart Failure</b> Due to (or as a consequence of): c. <b>Hypertension</b> Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Anil Uberoi MD</b>				29c. License number <b>D26748</b>		29d. Date signed (Month, Day, Year) <b>2/17/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANIL UBEROI MD 4419 FALLS RD BALTO MD 21211</b>									
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature <b>Anna B. Sparks</b>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 30,31 Per DVR Film G768 2-19-99 rja

Item 20b per FH,KB Film G768 2-18-99 rja

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Baby Boy Hardesty</b>				2. Date of Death Month Day Year <b>January 27 1999</b>		3. Time of Death <b>1815</b>	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>Unknown</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. <b>1</b>		8. Date of Birth (Month, Day, Year) <b>Jan. 27, 1999</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Millersville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>676 Stonewheel Court</b>		10f. Zip Code <b>21108</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>		16b. Kind of Business/Industry <b>N/A</b>		17. Father's Name (First, Middle, Last) <b>Douglas Perry Hardesty</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Karen Ann Siebert</b>		19a. Informant's Name/Relationship (Type, Print) <b>Douglas P. Hardesty - Father</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>676 Stonewheel Court, Millersville, MD 21108</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Date <b>2-2-99</b>		20d. Location - City or Town, State <b>Baltimore, MD</b>		21. Signature of Funeral Service Licensee <i>Patrick J. [Signature]</i>		
22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Anencephaly - Intra-uterine pregnancy @ 21 wks</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Cliff McClain M.D.</i>		
29c. License number <b>D06987</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 27 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CLIFFORD A. McCLAIN 1300 Ritchie Hwy ARNOLD MD 21012</b>		31. Date filed (Month, Day, Year) <b>JANUARY 27 1999</b>		
32. Registrar's Signature <i>[Signature]</i>		33. Date <b>FEB 19 1999</b>		34. Registrar's Name <b>B. Spade</b>		35. Registrar's Title <b>Registrar</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Johnson

2. Date of Death

February 17, 1999

3. Time of Death

8:30 A.M.

4a. Facility Name (If not institution, give street and number)

STELLA Morris 301 ST. Paul St.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

215-34-7677

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 1 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1214 Linderleaf Ct.

10f. Zip Code

21202

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Maintenance Engineer

16b. Kind of Business/Industry

Maintenance

17. Father's Name (First, Middle, Last)

Luellen Johnson

18. Mother's Name (First, Middle, Maiden Summa)

Tempey White

19a. Informant's Name/Relationship (Type, Print)

Helen Mae Johnson/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1214 Linderleaf Ct. Balt. MD 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Memorial Garden Feb. 22, 1999 Baltimore, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald A. Grayson

22. Name and Address of Facility

Ronald A. Grayson Funeral Service  
8312 Liberty Rd. Balt. MD 21244

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatoma

Due to (or as a consequence of):

b. End Stage Liver Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Johnson

29c. License number

D 40851

29d. Date signed (Month, Day, Year)

2/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dore Roseberry 301 St Paul Pl Baltimore 21202

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

P. Spaulding

State  
Registrar

ORIGINAL

JOHNSON, PAUL  
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert C. Klapka</b>				2. Date of Death Month Day Year <b>Feb. 17 1999</b>		3. Time of Death <b>7:10 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Med. Ctr.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>214-40-1792</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>56</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 30, 1942</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>705 50th Street</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Vietnam</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>11th</b>	
15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sub-Assembly</b>		16. Kind of Business/Industry <b>Auto-Manufacturer</b>		17. Father's Name (First, Middle, Last) <b>Fred Klapka</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Hellman</b>		19a. Informant's Name/Relationship (Type, Print) <b>Patricia L. Klapka/Wife</b>	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>705 50th Street, Baltimore Maryland 21224</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>		20c. Date <b>2/19/99</b>		20d. Location - City or Town, State <b>Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>David J. Weber Funeral Homes, P.A. 401 S. Chester St. Baltimore, Maryland 21231</b>		23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Ventricular fibrillation &amp; Asystole</b> Due to (or as a consequence of): b. <b>Suspected Myocardial Infarction</b> Due to (or as a consequence of): c. <b>Type 2 Diabetes</b> Due to (or as a consequence of): d. <b>Hypertension</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Feb. 18, 1999</b>	
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier 		29c. License number <b>D 0024353</b>		29d. Date signed (Month, Day, Year) <b>Feb. 18, 1999</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Mukesh Lohar MD, 1576 Merritt Blvd., Balto, MD 21222</b>	
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature 		33. Registrar's Title <b>Registrar</b>		34. Registrar's Address <b>1041</b>		35. Registrar's Phone <b>68760</b>	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





JOSEPH JOHN KOSYJANA  
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, II, 27, 28A-F PER MEO G768

Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Joseph John Kosyjana

2. Date of Death

FEBRUARY 13 1999 1829 P

3. Time of Death

4a. Facility Name (If not institution, give street and number)

5606 ALLENDER ROAD

4b. City, Town, or Location of Death

White Marsh

4c. County of Death

BALTIMORE

5. Social Security Number

217-24-2802

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 9, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

White Marsh

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5606 Allender Road

10f. Zip Code

21162

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Boiler Inspector

16b. Kind of Business/Industry

Insurance Company

17. Father's Name (First, Middle, Last)

John Joseph Kosyjana

18. Mother's Name (First, Middle, Maiden Surname)

Tillie Tipowitz

19a. Informant's Name/Relationship (Type, Print)

Pamela K. Chapman (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19312 Ensor Road, White Hall, MD 21161

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Trinity Russian Orth.

Date

2/18/99

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

Benjamin C. Williams

22. Name and Address of Facility

Schimunek Funeral Home, Inc.  
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

THERMAL INJURIES COMPLICATED BY ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

CLOTHING CATCHING ON FIRE

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALCOHOL INTOXICATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☒ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

2-13-99

28b. Time of Injury

Found 6:17

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

VICTIM OF HOUSE FIRE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5606 ALLENDER ROAD, BALTIMORE, MD.

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

FEBRUARY 14, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen S. Radentz, MD, 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

Benjamin C. Williams

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04915

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Evelyn Keefer</b>				2. Date of Death Month Day Year <b>FEBRUARY 15, 1999</b>				3. Time of Death <b>6:00PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>LORIEN NURSING HOME</b>				4b. City, Town, or Location of Death <b>COLUMBIA</b>				4c. County of Death <b>HOWARD</b>	
Funeral Director	5. Social Security Number <b>377-10-0978</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>96</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>1/7/1903</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>HOWARD</b>		10c. City, Town or Location <b>WOODBINE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3215 FLORENCE ROAD</b>		10f. Zip Code <b>21797</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BOOKKEEPER</b>		16b. Kind of Business/Industry <b>RETAIL</b>		17. Father's Name (First, Middle, Last) <b>WILLIAM F. WEISS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>CAROLINE M. (BRAUTIGAM)</b>	
	19a. Informant's Name/Relationship (Type, Print) <b>CAROLYN CLAY (DAUGHTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3215 FLORENCE ROAD WOODBINE, MD 21797</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY</b>		20c. Location - City or Town, State <b>2/20/99 ROSEDALE, MD</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>WITZKE FUNERAL HOMES, INC. 5555 TWIN KNOLL ROAD COLUMBIA, MD 21045</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>END STAGE DEGENERATION</b> Due to (or as a consequence of): <b>Recent Asymptomatic pneumonia</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b></b> Due to (or as a consequence of): <b></b>		Approximate Interval Between Onset and Death <b>4m</b> <b>4ks</b>			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D-34868</b>	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>Feb 16, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>D. B. 11055 Little Patuxent Pk Columbia, MD 21044</b>		31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <i>[Signature]</i>			
	State Registrar									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04916

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Naomi Lorraine Kile				2. Date of Death Month Day Year February 14, 1999				3. Time of Death 7:30 a.m.	
	4a. Facility Name (If not institution, give street and number) 4838 Ridge Road				4b. City, Town, or Location of Death Baltimore County				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 219-20-5312		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) April 9, 1923		9. Birthplace (State or Foreign Country) Baltimore, Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore County				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 4838 Ridge Road				10f. Zip Code 21237		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Housekeeping Own Home		
	17. Father's Name (First, Middle, Last) Vernon R. Baker				18. Mother's Name (First, Middle, Maiden Surname) Grace Phifer					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Robert L. Kile Sr. (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4838 Ridge Road Baltimore, Maryland 21237					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fork Methodist Church Cem. February 17, 1999 Fork, Maryland				20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee Mother Joseph Chynock				22. Name and Address of Facility Lassan Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Arteriosclerotic Cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier D. Phifer M.D.								
29c. License number D35411		29d. Date signed (Month, Day, Year) 2/2/99								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 618 Ridge Road, Baltimore, MD 21237										
31. Date filed (Month, Day, Year) FEB 19 1999		32. Registrar's Signature Sharon B. Sparks								





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04917

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Henry Lee</b>				2. Date of Death Month Day Year <b>February 15, 1999</b>		3. Time of Death <b>8:34 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>1305 Edmondson Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>242-24-1904</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>February 5, 1923</b>	
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>Baltimore</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>African American</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Construction Worker</b>	
	17. Father's Name (First, Middle, Last) <b>Savage Lee</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Privette</b>		19. Informant's Name/Relationship (Type, Print) <b>Mrs. Annie Wicks (sister)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2728 Guilford Ave. Balto. Md. 21218</b>	
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>		20c. Location - City or Town, State <b>Balto. Md.</b>		20d. Date <b>2/23/99</b>	
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Smoke Inhalation</b>		Approximate Interval Between Onset and Death	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>2/15/99</b>	
State Registrar	28b. Time of Injury <b>unk</b> M		28c. Injury of Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Victim of house fire</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>AT HOME</b>	
	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1305 Edmondson Ave</b>		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>James Lee MD</b>		29c. License number <b>O.C.M.E.</b>	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>February 16, 1999</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>J. LARON Wicks MD</b>		31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <b>James B. Spence</b>	
	31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <b>James B. Spence</b>		33. Date of Death <b>February 15, 1999</b>		34. Time of Death <b>8:34 A.M.</b>	

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State of Maryland / Department of Health and Mental Hygiene

Item 26 Per PHY Film G768 2-19-99 rja

## Certificate of Death

Reg. No.

99 04918

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>ETHELEE</b>				2. Date of Death Month Day Year <b>FEBRUARY 12, 1999</b>				3. Time of Death <b>2:45 PM</b>			
4a. Facility Name (If not institution, give street and number) <b>The Betty Jane and Creston G. Tate Foundation Chesapeake Hospice House</b>				4b. City, Town, or Location of Death <b>Long</b>				4c. County of Death <b>Anne Arundel</b>			
5. Social Security Number <b>466-46-5147</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 15, 1917</b>		9. Birthplace (State or Foreign Country) <b>Texas</b>			
Usual Residence of Decedent											
10e. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>113 Glenlea Drive</b>				10f. Zip Code <b>21060</b>		10g. Citizen of What Country? <b>U. S. A.</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>			16b. Kind of Business/Industry <b>Banking</b>				
17. Father's Name (First, Middle, Last) <b>Robert Coleman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Marie James</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Patricia Ann Bennett (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>113 Glenlea Drive Glen Burnie Maryland 21060</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Hill Cemetery</b>			20c. Location - City or Town, State <b>Edgewood, Texas</b>		20d. Date <b>2/18/99</b>		
21. Signature of Funeral Service Licensee <i>Michael C. Goffman</i>				22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>severe dementia</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____								Approximate Interval Between Onset and Death <b>years</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Wm Dring MD</i>				29c. License number <b>D 44804</b>		29d. Date signed (Month, Day, Year) <b>2/12/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>8028 Ritchie Highway Pasadena MD 21122 / KARIN DODGE MD</b>											
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature <i>B. Sparks</i>							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

04919

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elinor

2. Date of Death

Lane February 10, 1999 12:33

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

213-26-8817

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Aug. 15, 1926

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10a. Street and Number

719 N. Rosedale Street

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Domestic Engineer

16b. Kind of Business/Industry

Unknown

17. Father's Name (First, Middle, Last)

Phillip Vaughan

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Bradley

19a. Informant's Name/Relationship (Type, Print)

William H. Lane

Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

719 N. Rosedale Street Baltimore, Md. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrison Forest Veterans

Date

Feb. 16

20c. Location - City or Town, State

Owings Mills, Md.

21. Signature of Funeral Service Licensee

D. Prince Waters

22. Name and Address of Facility

Nutter Funeral Homes, Inc.  
2501 Gwynns Falls PKWY Baltimore, Md. 2121623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Congestive Heart Failure

Approximate  
Interval Between  
Onset and Death

10 min.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastDue to (or as a consequence of):  
Coronary Artery DiseaseDue to (or as a consequence of):  
Myocardial Infarction

10 mins.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Thomas W. Shuck MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

Feb. 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 N. Wolfe Street Baltimore, MD. 21287

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nellie Ligan

2. Date of Death

Feb 12 1999

Day Year

3. Time of Death

0245 Am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Baltimore City

5. Social Security Number

197-20-2898

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 2, 1917

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State Maryland 10b. County Baltimore City

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

XX ☐ Yes 2 ☐ No

10e. Street and Number

5525 Plainfield Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5 yrs.

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress/Barmaid

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Isaac William Judd

18. Mother's Name (First, Middle, Maiden Surname)

Mary Alice Jenkins

19a. Informant's Name/Relationship (Type, Print)

Jean F. Reese (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5525 Plainfield Avenue Baltimore, Md. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. 2-15-99

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lassahn Funeral Home

7401 Belair Rd. Baltimore, Md. 21236

23a. (Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.)

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Cardiomyopathy

Due to (or as a consequence of):

c. Mitral Valve Stenosis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Months

6 years

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Hepes Zoster

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alan Bentoni MD

29c. License number

D005344

29d. Date signed (Month, Day, Year)

Feb 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 Loch Raven Boulevard Baltimore MD 21239

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elsie L. Law</b>				2. Date of Death Month Day Year <b>February 17 1999</b>				3. Time of Death <b>11:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Manor Care - Ruxton</b>				4b. City, Town, or Location of Death <b>Towson</b>				4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>215-03-6282</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 23 1916</b>		9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Timonium</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>18 Ballybunion Ct.</b>				10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>John DeVaughn</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Fray</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Robert W. Law /son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18 Ballybunion Ct. Timonium, MD 21093</b>					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MeTRO Crematory</b>		Data <b>Feb 18 1999</b>		20c. Location - City or Town, State <b>Catonsville, MD</b>	
	21. Signature of Funeral Service Licensee <i>Anthony Colt Connelly</i>				22. Name and Address of Facility <b>Connolly Funeral Home of Dundalk 7110 Sollers Point Rd 21222</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immadiata Cause (Final disease or condition resulting in death) <b>a. Acute Stroke</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Dr. Ghiladi</i>		29c. License number <b>D-12849</b>		29d. Date signed (Month, Day, Year) <b>2-18-99</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. GHILADI, MD 7600 OSLER Dr. TOWSON, MD. 21204</b>									
	31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <i>B. Spaul</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

REB

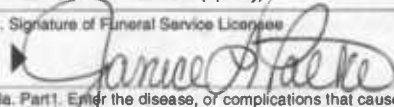
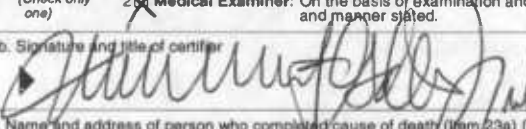
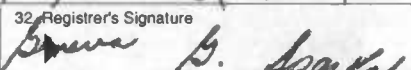


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gertrude M. Maskery				2. Date of Death Month Day Year FEBRUARY 17, 1999				3. Time of Death 0900				
	4e. Facility Name (If not institution, give street and number) 9000 BRIARCROFT LANE #104				4b. City, Town, or Location of Death LAUREL				4c. County of Death PRINCE GEORGES				
Funeral Director	5. Social Security Number 155-01-4831		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) April 13, 1921		9. Birthplace (State or Foreign Country) New Jersey		
	Usual Residence of Decedent										10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10a. State MD		10b. County Prince George		10c. City, Town or Location Laurel				10g. Citizen of What Country? USA					
10e. Street and Number 9000 Briarcroft Lane, #104				10f. Zip Code 20708				14g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier				16b. Kind of Business/Industry Food					
17. Father's Name (First, Middle, Last) James J. Johann						18. Mother's Name (First, Middle, Maiden Surname) Margaret Daugherty							
19a. Informant's Name/Relationship (Type, Print) Mary Anne Lundy/Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11700 Basswood Drive, Laurel, Maryland 20708							
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Greenwood Cemetery		Date 2/22/99		20c. Location - City or Town, State Trenton, New Jersey					
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
										24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier 						29c. License number D33954		29d. Date signed (Month, Day, Year) FEBRUARY 17, 1999					
30. Name and address of person who completed cause of death (Form 23a) (Type, Print) MARIO F. GOLUE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785													
31. Date filed (Month, Day, Year) FEB 19 1999				32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2025.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04923

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>David McMillian</b>				2. Date of Death Month <b>Feb.</b> Day <b>12</b> Year <b>99</b>		3. Time of Death <b>21:47pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>212-42-2921</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>54</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>07-12-44</b>	
	10e. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>406 E. Oliver Street</b>				10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bus Driver</b>		16b. Kind of Business/Industry <b>Company</b>			
	17. Father's Name (First, Middle, Last) <b>Richard Macabee</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Edward Padgett</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21202</b> <b>408 E. Oliver Street Baltimore, Maryland</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Mem. Gardens</b>		Date <b>02-19-99</b>		20c. Location - City or Town, State <b>Dundalk, MD</b>	
	21. Signature of Funeral Service Licensee <b>Bernad E Johnson</b>				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March F.H. 1101 E. North Avenue</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <b>Dr. Reed Winston, MD</b>				29c. License number <b>230406</b>		29d. Date signed (Month, Day, Year) <b>2/17/99</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2606 Liberty Heights Road</b>							
	31. Date filed (Month, Day, Year)				32. Registrar's Signature <b>Dr. Reed Winston, MD</b>			
	State Registrar							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruby V Marsh

2. Date of Death

Month

Day

Year

2 13 99

3. Time of Death

0145 AM

4a. Facility Name (If not institution, give street and number)

University of Maryland Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

232-60-8774

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

4/9/1936

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

214 WERNER ROAD

10f. Zip Code

21226

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

THOMAS JEFFERSON HENSLEY

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH MARCUM

19a. Informant's Name/Relationship (Type, Print)

ELIZABETH MADGE BAESCH - DAUG.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1469 NAPLES WAY, LIVERMORE, CA, 94550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD VETERANS CEMETERY

Date

2/16

20c. Location - City or Town, State

CROWNSVILLE, MD

21. Signature of Funeral Service Licensee

KELLY GREGORY FINK

22. Name and Address of Facility

FINK FUNERAL HOME, P.A.

426 CRAIN HWY., S.W., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. COPD

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MS Saba MD

29c. License number

P11781

29d. Date signed (Month, Day, Year)

2/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joanna M. Saba, 22 S. Greene St, Balto, MD 21201

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04925

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>James John Magee</u>				2. Date of Death Month <u>FEBRUARY</u> Day <u>13</u> Year <u>1999</u>		3. Time of Death <u>6:40 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Saint Joseph Medical Center</u>				4b. City, Town, or Location of Death <u>Towson</u>		4c. County of Death <u>Baltimore</u>	
Funeral Director	5. Social Security Number <u>168-16-4241</u>		6. Sex <u>1</u> M <u>2</u> F	7. Age (in yrs. last birthday) <u>78</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>NOV. 25 1920</u>	9. Birthplace (State or Foreign Country) <u>Pennsylvania</u>
	Usual Residence of Decedent 10a. State <u>Fla.</u> 10b. County <u>Dee</u> 10c. City, Town or Location <u>Fort Myers</u>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number <u>18537 Sandy Cove Dr.</u>				10f. Zip Code <u>33901</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u>-</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>postal worker</u>		16b. Kind of Business/Industry <u>U.S. Postal Service</u>		
17. Father's Name (First, Middle, Last) <u>John Magee</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Mary Sheridan</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Margaret Magee - wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>18537 Sandy Cove Dr. Fort Myers, Fla.</u>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>S.S. Peter + Paul Cemetery</u>		20c. Location - City or Town, State <u>Springfield, Pa.</u>		
21. Signature of Funeral Service Licensee <u>Krista J. Wells</u>				22. Name and Address of Facility <u>Evans Funeral Chapel</u> <u>8800 Harford Rd. Baltimore, Md 21234</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)				a. <u>VENTRICULAR &amp; SUPRAVENTRICULAR ARRHYTHMIAS.</u>				3 DAYS
				Due to (or as a consequence of):				
				b. <u>SEPSIS.</u>				1 DAY
				Due to (or as a consequence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				c. <u>ADULT RESPIRATORY DISTRESS SYNDROME -</u>				4 WEEKS
				Due to (or as a consequence of):				
				d. <u>VENTILATORY FAILURE. RENAL FAILURE.</u>				4 WEEKS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
<u>BOWEL ISCHEMIA</u>				<u>OBSTRUCTION ADHESIONS</u>				
<u>CORONARY ARTERY DISEASE - STATUS POST BYPASS GRAFT</u>								
<u>LIVER FAILURE</u>								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <u>Krista J. Wells</u>		29c. License number <u>D-35453</u>		
				29d. Date signed (Month, Day, Year) <u>2/13/99</u>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>LINDA BARR M.D., 120 SISTER PIERRE DRIVE, STE. 507 TOWSON, MARYLAND 21204</u>								
31. Date filed (Month, Day, Year) <u>FEB 19 1999</u>				32. Registrar's Signature <u>B. Sparks</u>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



DHHH 16 Rev 6/95





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-04927

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mae Virginia Martin</b>				2. Date of Death Month <b>February</b> Day <b>16</b> Year <b>1999</b>		3. Time of Death <b>7:02 P.M.</b>						
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland, Shock Trauma</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>						
Funeral Director	5. Social Security Number <b>194-26-6856</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10/4/1930</b>						
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>						
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>14 Selfridge Rd.</b>		10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>USA</b>							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
15. Decedent's Education (Specify only highest grade completed) <b>8th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Domestic</b>									
17. Father's Name (First, Middle, Last) <b>Thornton R. Judy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edith Weese</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Catherine Anderson / Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>325 S. Chester Street Baltimore, Md. 21231</b>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		20c. Location - City or Town, State <b>2/19/99 Baltimore, Md.</b>									
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Md. 21231</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>Complications of a right femur fracture</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>7 days</b> </td> </tr> <tr> <td>b. <b>Fall</b></td> </tr> <tr> <td>c. </td> </tr> <tr> <td>d. </td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Complications of a right femur fracture</b>	Approximate Interval Between Onset and Death  <b>7 days</b>	b. <b>Fall</b>	c.	d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Complications of a right femur fracture</b>	Approximate Interval Between Onset and Death  <b>7 days</b>											
	b. <b>Fall</b>												
	c.												
	d.												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
<b>Right renal mass consistent with cancer</b>  <b>Hypertension</b>						24a. Was an autopsy performed? <b>Approval</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>Feb. 9, 1999</b>		28b. Time of Injury <b>12:00noon</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
		28d. Describe how injury occurred <b>Subject fell at home.</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>at home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>14 Selfridge Road, Essex, Maryland</b>							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>February 17, 1999</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>													
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature 											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04928

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William R. May Jr.

2. Date of Death  
Month Day Year

February 15, 1999 7:41am

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

216-20-6498

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 13 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

317 Wye Road

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Inspector

16b. Kind of Business/Industry

Westinghouse

17. Father's Name (First, Middle, Last)

William R. MAY Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen Fowler

19a. Informant's Name/Relationship (Type, Print)

Alene M. May / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

317 Wye Road Baltimore Md. 21221

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forrest Cemetery 2/17/99 Owings Mills MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex

300 Mace Ave. Baltimore MD. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Ruptured Abdominal Aortic Aneurysm

Approximate Interval Between Onset and Death

4 Days

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Tobacco use, cholelithiasis,

Urinary Tract Infection

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D17992

29d. Date signed (Month, Day, Year)

2/15/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Khin Tun MD, 9000 Franklin Square Drive Baltimore, MD. 21237

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04929

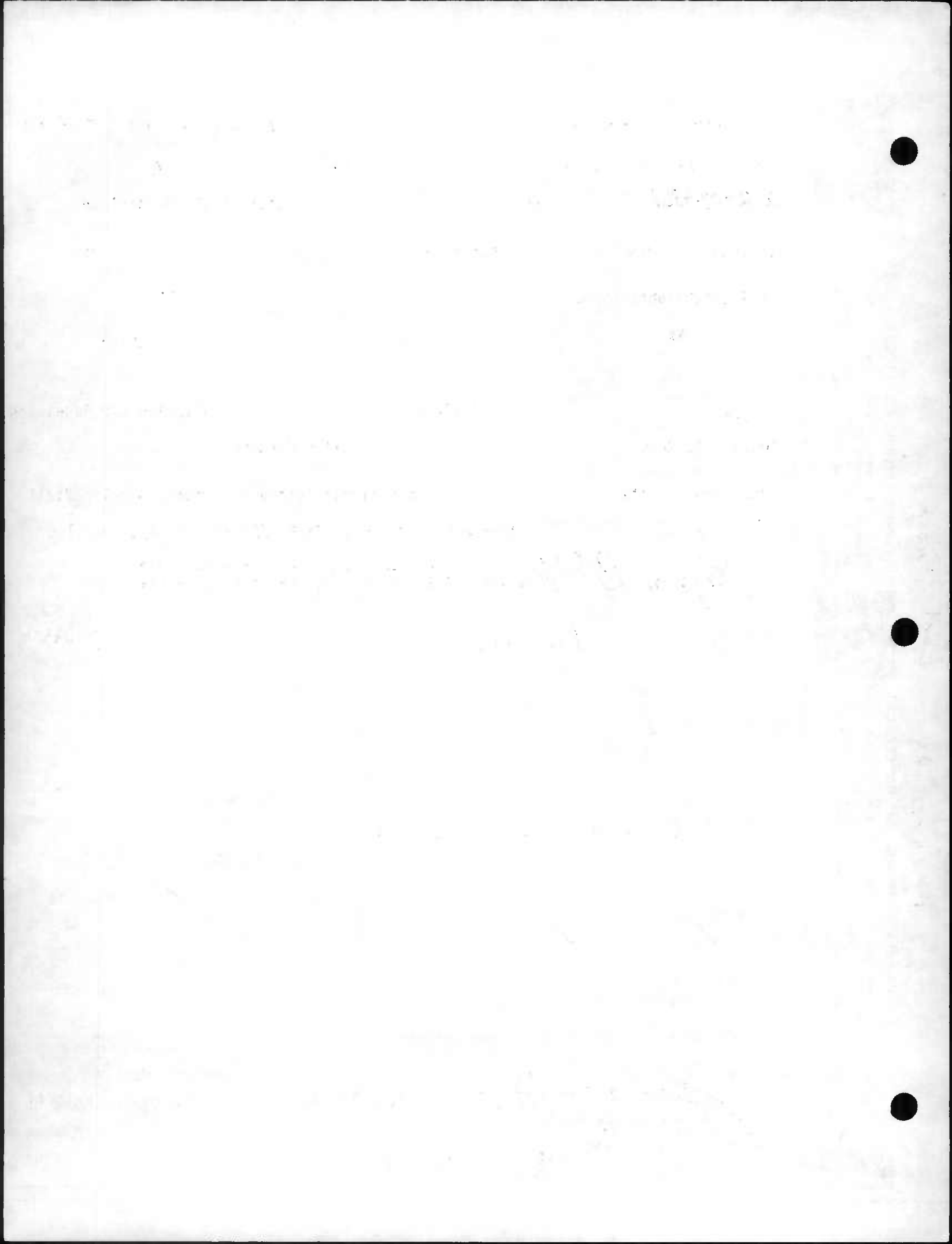
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Earl Morgan</b>				2. Date of Death Month <b>February</b> Day <b>18</b> Year <b>1999</b>		3. Time of Death <b>4:00 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Sindi Hospital of Baltimore</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>212-09-4867</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 12, 1916</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1118 Woodheights Avenue</b>		10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12+</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Traffic Clerk</b>		16b. Kind of Business/Industry <b>Shipping and Receiving</b>					
17. Father's Name (First, Middle, Last) <b>Francis E. Morgan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lilly Kennard</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Edna Morgan Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1118 Woodheights Avenue Baltimore, Maryland 21211</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Park</b>		20c. Date <b>2/20/99</b>		20d. Location - City or Town, State <b>Elkridge, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Lynn B. Henss</b>		22. Name and Address of Facility <b>Burgee-Henss Funeral Home PA 21211 3631 Falls Road, Baltimore, Maryland</b>							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Approximate Interval Between Onset and Death <b>2 weeks</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Irlandez MD</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>February 18 1999</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Irlandez MD</b>				31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature <b>B. Sparks</b>	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph A. Montesion				2. Date of Death Month Day Year February 16 1999		3. Time of Death 1:45pm		
	4a. Facility Name (If not institution, give street and number) St. Agnes Nursing & Rehabilitation Center				4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard		
Funeral Director	5. Social Security Number 150 18 9073		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Oct 14, 1926		
	9. Birthplace (State or Foreign Country) New Jersey		10a. State Maryland		10b. County Howard		10c. City, Town or Location Ellicott City		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7632 Coachlight Lane		10f. Zip Code 21043		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1948-49		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Management		16b. Kind of Business/Industry Federal Government					
17. Father's Name (First, Middle, Last) James Montesion				18. Mother's Name (First, Middle, Maiden Surname) Grace Vacca					
19a. Informant's Name/Relationship (Type, Print) Josephine M. Montesion/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7632 Coachlight Lane Ellicott City, MD 21043					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Cemetery		20c. Location - City or Town, State 2-20-99 Elkridge, MD					
21. Signature of Funeral Service Licensee Shawn A. Gellins - Witzke				22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e. PNEUMONIA Dua to (or as a consequence of):		f. DEMENTIA Dua to (or as a consequence of):		g. Dua to (or as a consequence of):		Approximate Interval Between Onset and Death 1 week YEARS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier J. Sparks		29c. License number D51860		29d. Date signed (Month, Day, Year) FEB 16, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN FISH MD 3460 ELICOTT CTR DR STE 103 ELICOTT CITY, MD 21043									
31. Date filed (Month, Day, Year) FEB 19 1999		32. Registrar's Signature J. Sparks							

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be delivered for use as the burial-transit certificate.

To Be Completed by Funeral Director  
 Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04931

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gertrude M. Murphy					2. Date of Death Month Day Year Feb. 16, 1999			3. Time of Death 1:15pm	
	4a. Facility Name (If not institution, give street and number) Look About Manor Nursing Home					4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll	
Funeral Director	5. Social Security Number 215-52-0545		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) March 13, 1902		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 1510 Stone Road				10f. Zip Code 21158			10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) George Yurek					18. Mother's Name (First, Middle, Maiden Surname) Frances Rozinski				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Catherine F. Shields (Daughter)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1112 Circle Drive, Arbutus, MD 21227				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery			Date 2/19/99		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228				
	23a. Pert I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CEREBRO VASCULAR ACCIDENT Due to (or as a consequence of): b. SEVERE DEMENTIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D17076		29d. Date signed (Month, Day, Year) 02-17-99			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3000 MANCHESTER ROAD, MANCHESTER, MD. 21102.									
	31. Date filed (Month, Day, Year) FEB 19 1999					32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04932

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Margaret McMahon</u>				2. Date of Death Month <u>February</u> Day <u>16</u> Year <u>1999</u>				3. Time of Death <u>0355</u>	
	4a. Facility Name (If not institution, give street and number) <u>Howard County General Hospital</u>				4b. City, Town, or Location of Death <u>Columbia</u>				4c. County of Death <u>Howard</u>	
Funeral Director	5. Social Security Number <u>579-44-6352</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>90</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Dec. 3, 1908</u>		9. Birthplace (State or Foreign Country) <u>Illinois</u>	
	Usual Residence of Decedent									
10a. State <u>MD</u>		10b. County <u>Howard</u>		10c. City, Town or Location <u>Dayton</u>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <u>5024 Morning Star Drive</u>				10f. Zip Code <u>21036</u>				10g. Citizen of What Country? <u>USA</u>		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Secretary</u>				16b. Kind of Business/Industry <u>U.S. Government</u>		
17. Father's Name (First, Middle, Last) <u>Edmund S. McMahon</u>					18. Mother's Name (First, Middle, Maiden Surname) <u>Margaret Teresa Carmody</u>					
19a. Informant's Name/Relationship (Type, Print) <u>Daniel J. McMahon (Cousin)</u>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5024 Morning Star Drive, Dayton, MD 21036</u>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Baltimore Washington Crem</u>		Date <u>2/17/99</u>		20c. Location - City or Town, State <u>Laurel, MD</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>					22. Name and Address of Facility <u>Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, MD 21045</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>pneumonia</u> Due to (or as a consequence of):</p> <p>b. <u>COPD</u> Due to (or as a consequence of):</p> <p>c. <u>CHF</u> Due to (or as a consequence of):</p> <p>d. <u>Esophageal Stricture</u></p>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>History of Atrial Fibrillation</u> <u>Hypertension</u> <u>Candidiasis - Urine &amp; Sputum</u>										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <u>[Signature]</u>				29c. License number <u>37011</u>				29d. Date signed (Month, Day, Year) <u>February 16 1999</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>9501 Old Annapolis Rd. Ellicott City MD 21043</u>										
31. Date filed (Month, Day, Year) <u>FEB 19 1999</u>				32. Registrar's Signature <u>[Signature]</u>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

89 04933

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ABE MANNING</b>				2. Date of Death Month Day Year <b>FEBRUARY 12 1999</b>		3. Time of Death <b>2305 hrs</b>		
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>251-54-0754</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov 26, 1935</b>		9. Birthplace (State or Foreign Country) <b>South Carolina</b>
	Usual Residence of Decedent								
10a. State <b>MD</b>			10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>9105 Tower Road</b>					10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>12th Grade</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>			16b. Kind of Business/Industry <b>Carpenter's Local 101</b>	
17. Father's Name (First, Middle, Last) <b>Theodore R. Manning</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Jessie A. Lumpkin</b>				
19a. Informant's Name/Relationship (Type, Print) wife <b>Albertha Manning</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9105 Tower Road Randallstown, MD 21133</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veteran Cemetery/Garrison</b>			Date <b>Feb 18</b>		20c. Location - City or Town, State <b>Owings Mills, MD</b>	
21. Signature of Funeral Service Licensee: 					22. Name and Address of Facility <b>Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Baltimore, MD 21216</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CVA</b>									Approximate Interval Between Onset and Death
e. Due to (or as a consequence of):									
b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number <b>037333</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 12, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>C. RAVI MD, NHC, BALTO. MD 21133</b>									
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





## Reg. No.

DHHM 16 Rev 6/95





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04935

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys Norris

2. Date of Death

Month 2 Day 13 Year 1999

3. Time of Death

12:38 PM

4a. Facility Name (If not institution, give street and number)

Irvington Knoll Nursing Home

4b. City, Town, or Location of Death

Balto.

4c. County of Death

Funeral  
Director

5. Social Security Number

212-05-7953

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 5-21-1911

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10e. State

MD.

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2736 LAURETTA AVE.

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

NURSES AID

16b. Kind of Business/Industry

BALTIMORE CITY

17. Father's Name (First, Middle, Last)

BENJAMIN BAILEY

18. Mother's Name (First, Middle, Maiden Surname)

FLORENCE COOPER

19a. Informant's Name/Relationship (Type, Print)

DOROTHY BARNES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2736 LAURETTA AVE. BALTO, MD. 21223

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS MEM. PARK

Date

2-18-99

20c. Location - City or Town, State

ARBUTUS MD.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.

1300 EUTAW PLACE BALTO, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

osteoarthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Anil Uberoi MD*

29c. License number

D26748

29d. Date signed (Month, Day, Year)

2/15/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANIL UBEROI MD 4419 FALLS RD BALTO MD 21211

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

Gladys Norris  
Baltimore, Maryland 21215-0020  
To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
(Medical  
Examiner)

1. Decedent's Name (First, Middle, Last)

Robert M. Niznik

2. Date of Death

February 14, 1999

3. Time of Death

3:30 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1111 Tace Drive #2C

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

5. Social Security Number

212-30-4357

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 3, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1111 Tace Dr. Apt. 2C

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Tile Layer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Louis Niznik

18. Mother's Name (First, Middle, Maiden Surname)

Mary Zygmunt

19a. Informant's Name/Relationship (Type, Print)

Gloria Niznik/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1111 Tace Dr. Apt. 2C Essex, Maryland 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

2/17/99

20c. Location - City or Town, State

Maryland

21. Signature of Funeral Service Licensee

Kathleen Weber CFSP

22. Name and Address of Facility

David J. Weber Funeral Homes, P.A.  
401 S. Chester St. Baltimore, MD 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Small cell lung cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. Sivasailam MD

29c. License number

D45530

29d. Date signed (Month, Day, Year)

2-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. SIVASAILAM, 6830, SUITE 206, HOSPITAL DRIVE, MD-21237

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

B. B. B. B.

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
(Medical  
Examiner)

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04937

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Paul J. Neyer</b>				2. Date of Death Month <b>February</b> Day <b>17</b> Year <b>1999</b>		3. Time of Death <b>11:45pm</b>													
	4a. Facility Name (If not institution, give street and number) <b>Charlestown Care Center</b>				4b. City, Town, or Location of Death <b>Catonsville</b>		4c. County of Death <b>Baltimore</b>													
Funeral Director	5. Social Security Number <b>216-05-4697</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr 14, 1913</b>													
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Catonsville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
10e. Street and Number <b>719 Maiden Choice Lane</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>United States</b>																
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>		16b. Kind of Business/Industry <b>Retail</b>																
17. Father's Name (First, Middle, Last) <b>Anthony J. Neyer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Madalina Worm</b>																
19a. Informant's Name/Relationship (Type, Print) <b>Ada M. Neyer/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>719 Maiden Choice Lane Catonsville, MD 21228</b>																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Johns Cemetery</b>		20c. Date <b>2-22-99</b>		20d. Location - City or Town, State <b>Ellicott City, MD</b>														
21. Signature of Funeral Service Licensee <b>Sam A. Collins - Witzke</b>		22. Name and Address of Facility <b>Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043</b>																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             {            Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Pneumonia</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>Weeks</b> </td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<b>Pneumonia</b>	Approximate Interval Between Onset and Death  <b>Weeks</b>	Due to (or as a consequence of):		b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.		
Immediate Cause (Final disease or condition resulting in death)  { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<b>Pneumonia</b>	Approximate Interval Between Onset and Death  <b>Weeks</b>																	
	Due to (or as a consequence of):																			
	b.	Due to (or as a consequence of):																		
	c.	Due to (or as a consequence of):																		
d.																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown														
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No														
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D47447</b>		29d. Date signed (Month, Day, Year) <b>February 18 1999</b>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Andrew... [unclear] 719 Maiden Choice Lane Catonsville Md</b>																				
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <b>[Signature]</b>																		





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04938

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Albert C. Noyes

2. Date of Death  
Month Day Year  
February 16 19993. Time of Death  
9:30pm

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director5. Social Security Number  
579-12-52796. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
84 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
Nov 15, 19149. Birthplace (State or Foreign  
Country)  
Washington DC

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3000 North Ridge Road

10f. Zip Code

21043

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Purchaser

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

Eliot Noyes

18. Mother's Name (First, Middle, Maiden Surname)

Mary Louise Camalier

19a. Informant's Name/Relationship (Type, Print)

Paul A. Capriolo/Executor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1912 Liberty Road Eldersburg, Maryland 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

2-20-99

20c. Location - City or Town, State

Wheaton, Maryland

21. Signature of Funeral Service Licensee

Steven A. Geller - witzke

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.  
4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

e.

Respiratory Arrest

Due to (or as a consequence of):

b.

Pneumonia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

1 hour

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient

26. Place of Death (Check only one)

3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven A. Geller MD

29c. License number

d34613

29d. Date signed (Month, Day, Year)

February 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Geller MD 9561 Old Annapolis Rd Ellicott City MD 21042

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

Steven A. Geller

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ellen W. Nelson</b>				2. Date of Death Month <b>February</b> Day <b>13</b> Year <b>1999</b>				3. Time of Death <b>11:38 am</b>		
	4a. Facility Name (If not Institution, give street and number) <b>Stella Maris Hospice</b>				4b. City, Town, or Location of Death <b>Baltimore County</b>				4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>177-07-8376</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 28, 1914</b>		9. Birthplace (State or Foreign Country) <b>Pittsburg, Pa.</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore County</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number <b>17 Woody Road</b>				10f. Zip Code <b>21221</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Housekeeping-Own Home</b>			
17. Father's Name (First, Middle, Last) <b>Arthur W. Williams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth C. Gurtner</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Judith E. Zeller (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17 Woody Road Baltimore, Maryland 21221</b>							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith February 16, 1999</b>				20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Robert Joseph Chopack</b>				22. Name and Address of Facility <b>Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>Pulmonary Edema</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <b>Robert Joseph Chopack</b>				29c. License number <b>D 15504</b>				29d. Date signed (Month, Day, Year) <b>2. 13. 99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093</b>											
31. Date Filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature <b>B. Sparks</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: NELSON, ELLEN

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04940

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nathan M. Needer				2. Date of Death Month Day Year February 14 1999		3. Time of Death 6:27 A.M.	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-03-6214		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 29, 1913	9. Birthplace (State or Foreign Country) Baltimore, Maryland
	Usual Residence of Decedent				10a. State Maryland		10b. County Baltimore	
To Be Completed by Funeral Director	10c. City, Town or Location Middle River		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 706 Wampler Road		10f. Zip Code 21220	
	10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 9/4/41-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 yrs. College (1-4 or 5+) n/a		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Field Accountant		16b. Kind of Business/Industry Rock Corporation	
	17. Father's Name (First, Middle, Last) Francis Joseph Needer (dec'd 1944)				18. Mother's Name (First, Middle, Maiden Surname) Anna Barbara Willick			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Linda Lee Ey (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Wampler Road Middle River, Maryland 21220			
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Memorial Gardens		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 2/18/99	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility E.F. Lassahn Funeral Home 11750 Belair Road Kingsville, Maryland 21087			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of): b. Atrial Fibrillation Due to (or as a consequence of): c. Hypovolemia Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 1 Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Status Post Myocardial Infarction X 2 Chronic Obstructive Pulmonary Disease Type 2 Diabetes Mellitus							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number RD186478		29d. Date signed (Month, Day, Year) 2/14/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Pedro J. Amador, 9000 Franklin Square Drive, Baltimore, Maryland 21237								
31. Date filed (Month, Day, Year) FEB 19 1999		32. Registrar's Signature 						

NEEDER, Nathan M.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04941

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>EGIL LOUIS OLSEN</b>				2. Date of Death Month Day Year <b>FEBRUARY 16 1999</b>		3. Time of Death <b>11:57AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Eastpoint Rehab &amp; Nursing Center</b>				4b. City, Town, or Location of Death <b>Eastpoint</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>213-05-2342</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 27 1907</b>	
9. Birthplace (State or Foreign Country) <b>Larvik-Norway</b>							

10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Timonium</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
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10e. Street and Number <b>300 Lochview Terrace</b>		10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>USA</b>	
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11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
--	--	---	--	--	--	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>n/a</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Steamfitter</b>		16b. Kind of Business/Industry <b>Construction</b>	
--	--	---	--	---	--

17. Father's Name (First, Middle, Last) <b>Odin Olsen</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Olefine Jansen</b>	
--	--	--	--

19a. Informant's Name/Relationship (Type, Print) <b>Dr. Louis O. Olsen/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2311 Killoran Rd., Timonium, MD 21093</b>	
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20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Balto. Wash. Crematory 2/20/99</b>		20c. Location - City or Town, State <b>Laurel, MD</b>	
---	--	---	--	--	--

21. Signature of Funeral Service Licensee <b>Bryan W. Clary</b>		22. Name and Address of Facility <b>Lemmon Funeral Home 10 W. Padonia Rd, Timonium, MD 21093</b>	
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE RESPIRATORY FAILURE</b>		Approximate Interval Between Onset and Death <b>1 DAY</b>	
---	--	--	--

Immediate Cause (Final disease or condition resulting in death) <b>ACUTE RESPIRATORY FAILURE</b>		Due to (or as a consequence of):	
---	--	----------------------------------	--

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>ARTERIOSCLEROTIC HEART DISEASE</b>		Due to (or as a consequence of):	
---	--	----------------------------------	--

Due to (or as a consequence of):			
----------------------------------	--	--	--

Due to (or as a consequence of):			
----------------------------------	--	--	--

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>ISCHEMIC HEART DISEASE</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
---	--	--	--

24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
---	--	---	--

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
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27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
---	--	--	--	---------------------------------	--	---	--	-----------------------------------	--

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
--	--	--	--

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>B. C. Veneracion MD PA</b>		29c. License number <b>D13664</b>		29d. Date signed (Month, Day, Year) <b>Feb 16, 1999</b>	
--	--	--	--	--------------------------------------	--	--	--

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>B.C. VENERACION JR MD PA 1576 MERRITT BLVD, BALTO, MD. 21222</b>	
---	--

31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <b>B. Sparks</b>	
---	--	---	--

33. State Registrar <b>State Registrar</b>	
---	--

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

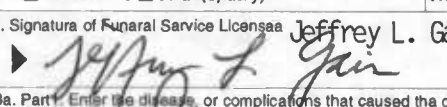
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Jean McLane Starr O'Donovan</b>					2. Date of Death Month <b>February</b> Day <b>18</b> Year <b>1999</b>		3. Time of Death <b>6:30 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Manor Care Ruxton Nursing Center</b>					4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore Co.</b>		
<b>Funeral Director</b>	5. Social Security Number <b>212-03-6084</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 23, 1910</b>		9. Birthplace (State or Foreign Country) <b>Baltimore, Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Baltimore Co.</b>		10c. City, Town or Location <b>Towson</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>7001 North Charles Street</b>					10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>United States of America</b>			
11. Marital Status <input type="checkbox"/> Navar Marriad <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>03</b>					18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Proof Reader</b>			16b. Kind of Business/Industry <b>Anne Arundle Co.</b>		
17. Father's Name (First, Middle, Last) <b>Edward James Starr</b>					18. Mother's Name (First, Middle, Maiden Sumama) <b>Elizabeth Virginia Zoller</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Mr. John T. Vance, III (Nephew)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13333 Long Green Pike Baldwin, Maryland 21013</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>			Data <b>02/20/99</b>		20c. Location - City or Town, State <b>Woodlawn, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Jeffrey L. Gair</b> 					22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Acute Stroke</b> Dua to (or as a consequence of):</p> <p>b.  Dua to (or as a consequence of):</p> <p>c.  Dua to (or as a consequence of):</p> <p>d.  Dua to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>Weeks</b></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



cm

Unknown 99-026

Robert Ifeanyt Onwubiko

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State of Maryland / Department of Health and Mental Hygiene

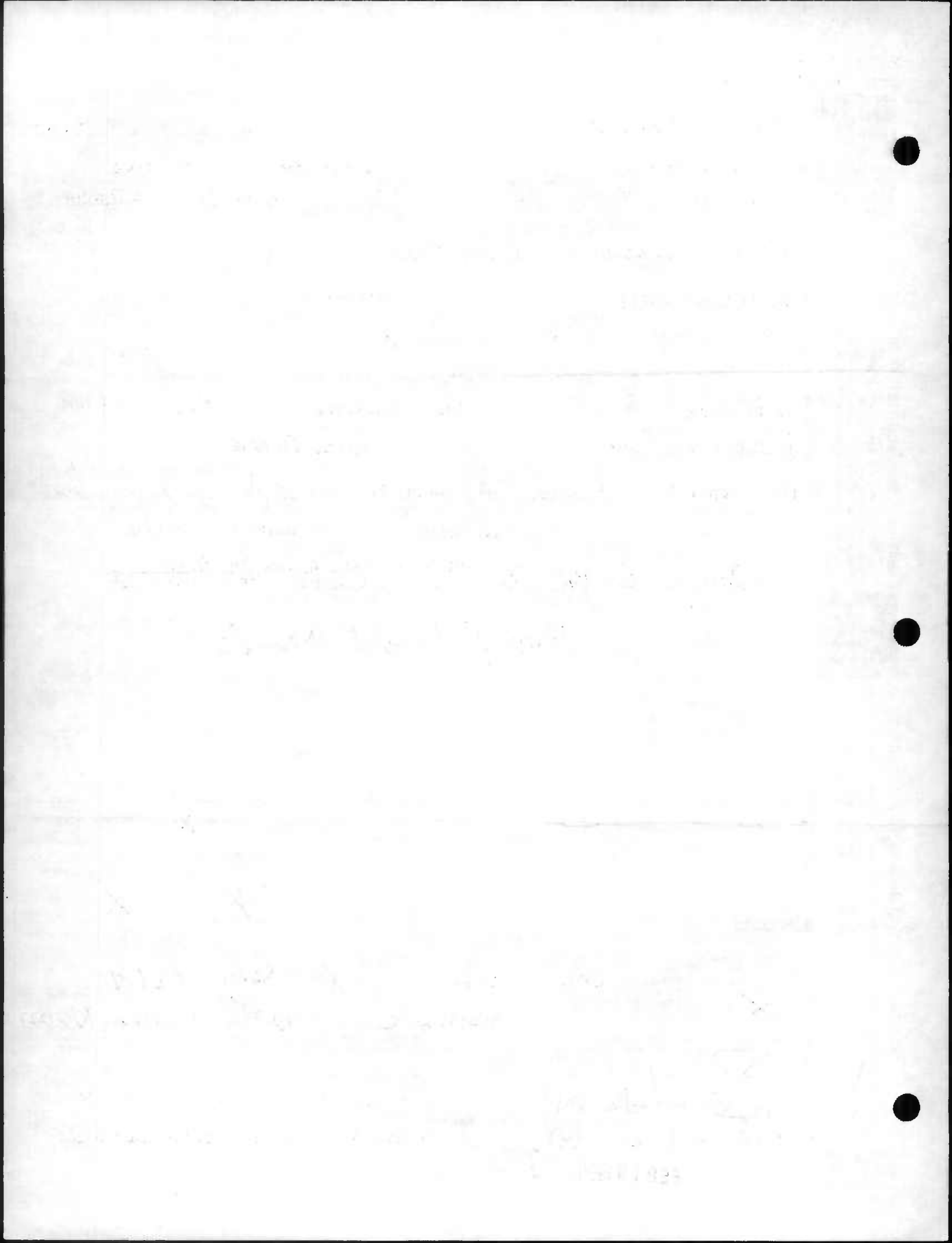
### Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT ONWUBIKO</b>						2. Date of Death Month Day Year <b>February 07, 1999</b>		3. Time of Death <b>3:53 A.M.</b>			
	4a. Facility Name (If not institution, give street and number) <b>42 Twin Circle Way North</b>						4b. City, Town, or Location of Death <b>Landsdowne</b>		4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>UNKNOWN</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>38</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10-12-60</b>		9. Birthplace (State or Foreign Country) <b>NIGERIA</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>NIGERIA</b>		10b. County <b>UNKNOWN</b>		10c. City, Town or Location <b>EBUTA-METTA</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number <b>69 IBADAN STREET</b>				10f. Zip Code <b>UNKNOWN</b>		10g. Citizen of What Country? <b>NIGERIA</b>					
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 TH GRADE</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SELF EMPLOYED</b>			16b. Kind of Business/Industry <b>BUSINESS MAN</b>						
	17. Father's Name (First, Middle, Last) <b>IFEDIOTU ONWUBIKO</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN OKAFOR</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>OBY MARTINA NRIAGU / SISTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>L9C6T1 63 FONTHILL RD, UNIT 22, HAMILTON-ONTARIO CANADA</b>							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>UNKNOWN</b>		Date <b>UNKNOWN</b>		20c. Location - City or Town, State <b>NIGERIA</b>					
	21. Signature of Funeral Service Licensee <b>Vaughn C. Greene</b>		22. Name and Address of Facility <b>VAUGHN C. GREENE FUNERAL SERVICE 5151 BALD. NATL PIKE, BALD. MD. 21229</b>									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Multiple Gunshot Wounds</b>										Approximate interval Between Onset and Death	
	Immediata Causa (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last											
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
											24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene	
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>UNK</b>		28b. Time of Injury <b>UNK</b> M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject shot</b>			
State Registrar	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>February 08, 1999</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TARON LOCKE MD</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>											
	31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <b>[Signature]</b>									

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Melvin Charles Oliver</b>				2. Date of Death Month Day Year <b>FEBRUARY 13, 1999</b>		3. Time of Death <b>5:26PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>214-12-2898</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>August 26, 1920</b>		9. Birthplace (State or Foreign Country) <b>Baltimore, Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore County</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>106 Sipple Avenue</b>				10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerical Worker</b>		16b. Kind of Business/Industry <b>B.G. &amp; E.</b>		
17. Father's Name (First, Middle, Last) <b>Samuel C. Oliver</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Hildebrande</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Norma P. Oliver (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>106 Sipple Avenue Baltimore, Maryland 21236</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith February 18, 1999</b>		Date <b>February 18, 1999</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>RESPIRATORY FAILURE</b>								<b>24 HOURS</b>
Due to (or as a consequence of): <b>PNEUMONIA</b>								<b>DAYS</b>
Due to (or as a consequence of): <b>SEPSIS</b>								<b>24 HOURS</b>
Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MYOCARDIAL INFARCTION</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
<b>RENAL FAILURE</b>								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>DEGENERATIVE NEUROMUSCULAR DISEASE</b>								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D35453</b>		29d. Date signed (Month, Day, Year) <b>2/14/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>LINDA BARR, M.D., 120 SISTER PIERRE DRIVE, TOWSON, MARYLAND 21204</b>								
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>								
32. Registrar's Signature <i>[Signature]</i>								

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

89 04945

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>SHEILA Elaine Oliver</i>				2. Date of Death Month <i>February</i> Day <i>15</i> Year <i>1999</i>		3. Time of Death <i>4:15 pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>Maryland General Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore City</i>		4c. County of Death <i>2/12</i>	
Funeral Director	5. Social Security Number <i>215-74-7678</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>39</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>May 29, 1959</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>Maryland</i>	10b. County <i>N/A</i>	10c. City, Town or Location <i>BALTIMORE</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <i>642 SMITHSON Street</i>			10f. Zip Code <i>21217</i>		10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th grade</i> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>			
17. Father's Name (First, Middle, Last) <i>HARRY Lee Oliver</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>LOUISE Watkins</i>				
19a. Informant's Name/Relationship (Type, Print) <i>LOUISE Watkins</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>642 SMITHSON Street BALTIMORE, Md 21217</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt Zion Cemetery</i>		Date <i>2-19-99</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>
21. Signature of Funeral Service Licensee <i>John H. Harris</i>				22. Name and Address of Facility <i>CHATHAM - HARRIS D.H. 3440 REISTERSTOWN ROAD BALTIMORE, MD 21215</i>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <i>Acute anterior myocardial infarction</i> Due to (or as a consequence of):							
	b. <i>Diabetic ketoacidosis</i> Due to (or as a consequence of):							
	c. <i>Diabetes mellitus</i> Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>John M. Bentley</i>		29c. License number <i>P 12668</i>		29d. Date signed (Month, Day, Year) <i>2/15/99</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>John Bentley, M.D. c/o Maryland General Hospital</i>								
31. Date filed (Month, Day, Year) <i>FEB 19 1999</i>				32. Registrar's Signature <i>John P. Sparks</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>George Pappas</b>				2. Date of Death Month <b>February</b> Day <b>15</b> Year <b>1999</b>		3. Time of Death <b>0755</b>
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-66-1969</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>41</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>July 17, 57</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	10a. State <b>Md.</b>			10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>508 S. Newkirk St.</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cook</b>		16b. Kind of Business/Industry <b>Restaurant</b>			
17. Father's Name (First, Middle, Last) <b>John Pappas</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sylvia Kalfas</b>			
19a. Informant's Name/Relationship (Type, Print) <b>John Pappas/ Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>508 S. Newkirk St., Balto., Md. 21224</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		20c. Location - City or Town, State <b>2-18-99 Balto., Md.</b>			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md. 21222</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. sepsis and endocarditis</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>end stage renal disease on hemodialysis, asthma, mental retardation, schizophrenia</b>							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier  <b>Kathryn J. Eubank MD</b>		29c. License number <b>97015</b>		29d. Date signed (Month, Day, Year) <b>February 15, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kathryn J. Eubank, MD Johns Hopkins Bayview Hospital, Baltimore, Maryland</b>							
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 04947

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wilbert Edward Pomier		2. Date of Death Month Day Year Feb 14, 1999		3. Time of Death 6:45 Pm
	4a. Facility Name (If not institution, give street and number) 3950 Hickory Avenue		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A/
Funeral Director	5. Social Security Number 212-40-7372	6. Sex XXM 2□ F	7. Age (In yrs. last birthday) 54	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) March 21, 1944		9. Birthplace (State or Foreign Country) Balto, Md		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Md		10b. County N/A
	10c. City, Town or Location Baltimore		10d. Inside City Limits XXYes 2□ No		
	10e. Street and Number 3950 Hickory Avenue		10f. Zip Code 21211		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1□ Never Married XXMarried 3□ Widowed 4□ Divorced		12. Was Decedent Ever in U.S. Armed Forces? XXYes 2□ No If Yes, Give Year or Dates 1966-1968		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes XXNo Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker
17. Father's Name (First, Middle, Last) Wilbert Joseph Pomier		18. Mother's Name (First, Middle, Maiden Surname) Doris Elizabeth Smith			
19a. Informant's Name/Relationship (Type, Print) Thea H. Pomier (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3950 Hickory Avenue Balto, MD 21211			
20a. Method of Disposition 1□ Burial XXCremation 3□ Removal from State 4□ Donation 5□ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Location - City or Town, State Towson, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Burgee-Henss Funeral Home, P.A. 3631 Falls Rd. Balto, MD 21211			
Physician /Medical Examiner	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Brain Cancer Due to (or as a consequence of):				Approximate Interval Between Onset and Death 6 M
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of):				
	g. Due to (or as a consequence of):				
	h. Due to (or as a consequence of):				
	i. Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1□ Yes 2XNo 3□ Probably 4□ Unknown	
24a. Was an autopsy performed? 1□ Yes 2XNo				24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2XNo	
25. Was case referred to medical examiner? 1□ Yes 2XNo		26. Place of Death (Check only one) Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA Other: 4□ Nursing Home 5XResidence 6□ Other (Specify)			
27. Manner of Death 1XNatural 5□ Pending Investigation 2□ Accident 6□ Could not be determined 3□ Suicide 4□ Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1□ Yes 2□ No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 			
29c. License number D23076		29d. Date signed (Month, Day, Year) 2-16-99			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Richard L. Diamond 3730 Falls Rd Balt Md 21211					
31. Date filed (Month, Day, Year) Feb 16 1999		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04948

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rose Peddicord

2. Date of Death

Month Day Year  
February 16 1999

3. Time of Death

2:10 pm

4a. Facility Name (If not institution, give street and number)

Sunrise Assisted Living

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

214-05-2124

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 7, 1917

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Harwood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4460 Solomons Island Road

10f. Zip Code

20776

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Frances Wisner

18. Mother's Name (First, Middle, Maiden Surname)

Rose Young

19a. Informant's Name/Relationship (Type, Print)

Michael Peddicord - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4460 Solomons Island Road, Harwood, MD 20776

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

2/18

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Thomas Hardesty

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

pneumonia

Due to (or as a consequence of):

b.

Dementia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

20

glean

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael J. Laperriere

29c. License number

D11438

29d. Date signed (Month, Day, Year)

17 Feb 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL J. LAPERRIERE 600 RIDGELY AVE STE 120 ANNAPOLIS MD 21401

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

John A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret Veronica Pfeifer</b>				2. Date of Death Month <b>February</b> Day <b>13</b> , Year <b>1999</b>		3. Time of Death <b>4:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>216-05-6031</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 20, 1911</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Timonium</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2300 Dulaney Valley Road</b>				10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Ervin Schario</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Dooling</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Margaret J. Pecora / Cousin</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2706 Greene Road Baldwin, MD 21013</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore National Cem.</b>		Date <b>2/18/99</b>		20c. Location - City or Town, State <b>Catonsville, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Timothy Harman</b> <i>Timothy S. Harman</i>				22. Name and Address of Facility <b>Leonard J. Ruck, Inc. Funeral Home</b> <b>5305 Harford Road Baltimore, MD 21214</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Atherosclerotic Cardiovascular Disease.</b> Due to (or as a consequence of): <b>b. Chronic Renal insufficiency</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Dementia.</b> <b>Asbestosis</b> <b>Cellulitis.</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia.</b> <b>Asbestosis</b> <b>Cellulitis.</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Christopher Ish</i>				29c. License number <b>053283</b>		29d. Date signed (Month, Day, Year) <b>2/15/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Christopher Ish, Stella Maris Nursing Home</b>								
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature <i>Benita B. Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item:17, per F.H G-768 2/19/99 reb

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Edward Petr

2. Date of Death

Month  
2

Day  
12

Year  
99

3. Time of Death

10:40 AM

4a. Facility Name (If not institution, give street and number)

Ivy Hall Geriatric

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

217-24-3612

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 22, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

342 Elinor Avenue

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

☐ Navar Married ☒ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 yrs.

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lineman

16b. Kind of Business/Industry

Baltimore Gas & Electric

17. Father's Name (First, Middle, Last)

John Joseph Petr, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Rose Lecny

19a. Informant's Name/Relationship (Type, Print)

Mrs. Elizabeth M. Petr

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

342 Elinor Avenue Baltimore, Maryland 21236

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer Cem. 2-15-99

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lassahn Funeral Home

7401 Belair Rd.

Baltimore, Md. 21236

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE PARKINSONS DISEASE

Due to (or as a consequence of):

b. DEMENTIA

Due to (or as a consequence of):

c. DEPRESSION

Due to (or as a consequence of):

d. MALNUTRITION

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sarinder K. Telle M.D.

29c. License number

D27188

29d. Date signed (Month, Day, Year)

2/12/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sarinder K. Telle 2 Market Place Baltimore MD 21222

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

Bruce S. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

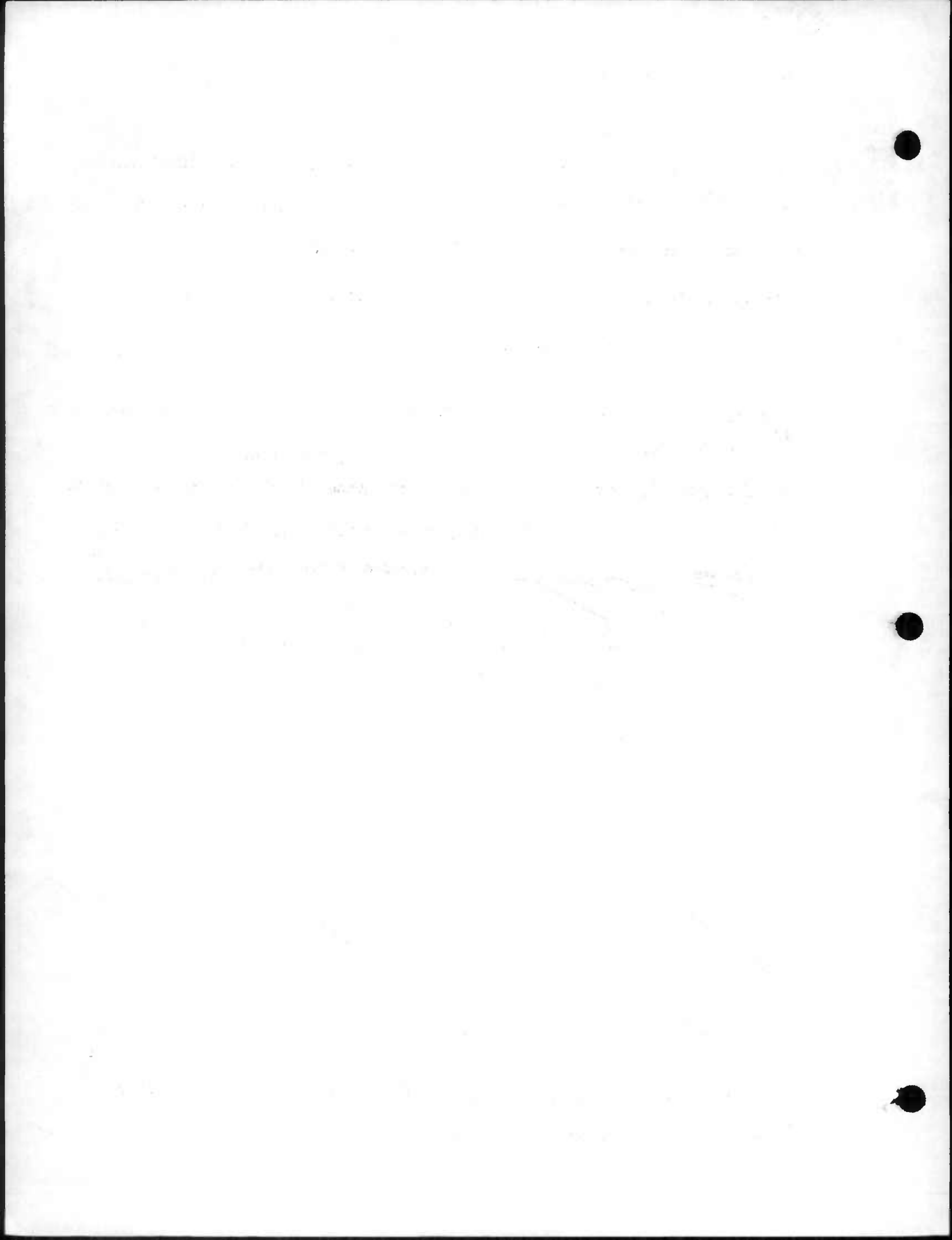
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William George Richardson

2. Date of Death

February 18 1999

3. Time of Death

12:15AM

4a. Facility Name (If not institution, give street and number)

Genesis Multi Medical

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-30-0290

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

8. Date of Birth

May 15, 1931

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1515 Charmuth Road

10f. Zip Code

21093

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No Korean Conflict

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Service Manager

16b. Kind of Business/Industry

Telecommunications

17. Father's Name (First, Middle, Last)

George Theodore Richardson

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Vorkert

19a. Informant's Name/Relationship (Type, Print) (Wife)

Mrs. Patricia Jean (Lovell) Richardson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1515 Charmuth Road Lutherville, Maryland 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

02/22/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Jeffrey L. Gair

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Rd. Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. Aspiration

Due to (or as a consequence of):

c. Anoxic Encephalopathy

Due to (or as a consequence of):

d. Ant. MI

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Sharpe

29c. License number

D24569

29d. Date signed (Month, Day, Year)

2/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar





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State of Maryland / Department of Health and Mental Hygiene

99 04952

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LIESE LOTTE RING				2. Date of Death Month Day Year February 18 <sup>th</sup> 1999		3. Time of Death 12:57 AM													
	4a. Facility Name (If not institution, give street and number) Mvta Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel													
Funeral Director	5. Social Security Number 216-42-8606	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	8. Date of Birth (Month, Day, Year) JULY 13, 1932	9. Birthplace (State or Foreign Country) GERMANY															
	Usual Residence of Decedent																			
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
10e. Street and Number 410 WELHAM AVENUE				10f. Zip Code 21061		10g. Citizen of What Country? GERMANY														
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME														
17. Father's Name (First, Middle, Last) ADAM SCHMIDT				18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH SCHITKICK																
19a. Informant's Name/Relationship (Type, Print) BETTY GREEN (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 WELHAM AVENUE, GLEN BURNIE, MD. 21061																
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CENTER LLC.		Date 2/20/99		20c. Location - City or Town, State CHESTER, MD.														
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Aspiration pneumonia</td> <td>Two days</td> </tr> <tr> <td>b.</td> <td></td> <td></td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Aspiration pneumonia	Two days	b.			c.			d.		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Aspiration pneumonia	Two days																	
	b.																			
	c.																			
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																				
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																				
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																
28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																				
29b. Signature and title of certifier 				29c. License number D48006		29d. Date signed (Month, Day, Year) February 18, 1999														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOFI BOAHITEY, 301 Hosp- Dr, Glen Burnie, MD 21061																				
31. Date filed (Month, Day, Year) FEB 19 1999		32. Registrar's Signature 																		

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Julia Restrepo

2. Date of Death

February 17, 1999

3. Time of Death

6:00 P.M.

4a. Facility Name (If not institution, give street and number)

500 W. University Parkway

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

132-14-2279

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept. 12, 1912

9. Birthplace (State or Foreign Country)

Colombia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

500 W. University Parkway

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Anthony Mallarino

18. Mother's Name (First, Middle, Maiden Surname)

Magola Pardo

19a. Informant's Name/Relationship (Type, Print)

George Restrepo Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1008 W. 37th Street, Baltimore, Maryland 21211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Alphonsus Cemetery

Date

2/22/99

20c. Location - City or Town, State

Woodstock, Maryland

21. Signature of Funeral Service Licensee

Lynn B. Henss

22. Name and Address of Facility

Burgee-Henss Funeral Home PA 21211

3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

TERMINAL CARDIAL ARRHYTHMIA

Approximate Interval Between Onset and Death

MINUTES

a. Due to (or as a consequence of):

CORONARY ARTERY INSUFFICIENCY 10 YEARS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 25 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASTHMATIC BRONCHITIS

ALLERGIC SENSITIVITY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph D. Notarangelo M.D.

29c. License number

D07613

29d. Date signed (Month, Day, Year)

FEBRUARY 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH D. NOTARANGELO M.D. 301 ST. PAUL PLACE BALTIMORE 21202

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

Benita G. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04954

Rohe, Mary  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Mary J. Rohe				2. Date of Death Month Day Year February 13, 1999				3. Time of Death 8:56pm			
4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Roseale				4c. County of Death Baltimore			
5. Social Security Number 213-26-6751		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 16, 1929		9. Birthplace (State or Foreign Country) Petersburg, Virginia			
10a. State Maryland				10b. County Baltimore				10c. City, Town or Location Bradshaw			
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 11016 Pfeffers Road				10f. Zip Code 21021			
10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) n/a			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical				16b. Kind of Business/Industry State of Maryland				17. Father's Name (First, Middle, Last) Floyd Dickens			
18. Mother's Name (First, Middle, Maiden Surname) Anna Valenta				19a. Informant's Name/Relationship (Type, Print) Joseph C. Rohe (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11016 Pfeffers Road Bradshaw, Maryland 21021			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Joseph's Cem. (Fullerton)				20c. Location - City or Town, State Baltimore, Maryland 21236			
21. Signature of Funeral Service Licensee E. F. Lassahn				22. Name and Address of Facility E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Maryland 21087				23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Adenocarcinoma of the Lung Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 18 hours 3 days			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type II Diabetes				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M			
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier K. S. L.			
29c. License number RD185264				29d. Date signed (Month, Day, Year) February 13, 1999				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Karl Spector, 9000 Franklin Square Drive, Baltimore, MD 21237			
31. Date filed (Month, Day, Year) FEB 19 1999				32. Registrar's Signature B. Sparks				State Registrar			





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Bernard Rideout

2. Date of Death

February 13 1999

Day Year

3. Time of Death

1035

4a. Facility Name (If not institution, give street and number)

Mercy Hospital

4b. City, Town, or Location of Death

Baltimore, MD

4c. County of Death

Baltimore

5. Social Security Number

577-58-2600

6. Sex

M 2 F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB 14 1941

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

H/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes 2 No

10e. Street and Number

410 W. Franklin Street #4A

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

Private Business

17. Father's Name (First, Middle, Last)

UNK.

18. Mother's Name (First, Middle, Maiden Surname)

JACQUELINE RIDEOUT

19a. Informant's Name/Relationship (Type, Print)

BILLY RIDEOUT / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

410 W. Franklin St #4A Baltimore, Md 21201

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

2/20/99

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHATHAM - HARRIS &amp; A. 5240 RISTERS ROAD BALTIMORE, MD 21111

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aortic aneurysm

Due to (or as a consequence of):

b. Renal failure

Due to (or as a consequence of):

c. Hepatic failure

Due to (or as a consequence of):

d. Abdominal aortic aneurysm

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

AU 4176435C9998

29d. Date signed (Month, Day, Year)

Feb 13 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William M. Caldwell, Jr. UMMS 22 S. Greene St. Baltimore, MD

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 18,20b per F.H G-769 3/4/99 reb

Certificate of Death

Reg. No.

99 04956

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carroll Joseph Roth				2. Date of Death Month Day Year February 14 1999		3. Time of Death 02:00 A.M.
	4a. Facility Name (If not institution, give street and number) Fallston General Hospital				4b. City, Town, or Location of Death Fallston		4c. County of Death Harford
Funeral Director	5. Social Security Number 217-18-1543	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12/15/1923	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County Harford	10c. City, Town or Location Belair			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1300 Marywood Drive			10f. Zip Code 21014		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager		16b. Kind of Business/Industry Chemical Co.		
	17. Father's Name (First, Middle, Last) Charles Roth				18. Mother's Name (First, Middle, Maiden Surname) Catherine J. Donhouser		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) June Roth			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 Marywood Drive, Belair, Maryland 21014			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility John C. Miller Inc. 6415 Belair road Baltimore, Maryland 21206			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Electromechanical dissociation</i> Due to (or as a consequence of): b. <i>End stage Ischemic Cardiomyopathy</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 2 hrs. 5 years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstructive pulmonary disease Severe Mitral regurgitation and Tricuspid regurgitation.</i>						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> Attending		29c. License number D-16444		29d. Date signed (Month, Day, Year) February 14th 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY-S. NAIR M.D. 2112 Belair Road. Fallston. MD 21047.							
31. Date filed (Month, Day, Year) FEB 19 1999		32. Registrar's Signature <i>[Signature]</i>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04957

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Olivia Stokes</b>				2. Date of Death Month Day Year <b>February 16, 1999</b>		3. Time of Death <b>10:40 PM.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>218-28-7084</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12-20-32</b>	
	9. Birthplace (State or Foreign Country) <b>SC</b>		10a. State <b>M.D.</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
Usual Residence of Decedent								
10a. State <b>M.D.</b>			10b. County <b>NA</b>			10c. City, Town or Location <b>Baltimore</b>		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number <b>21 Wolfe Trappe Court</b>			10f. Zip Code <b>21236</b>		
10g. Citizen of What Country? <b>USA</b>			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>2-years</b>		
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>L.P.N.</b>			16b. Kind of Business/Industry <b>Hospital</b>			17. Father's Name (First, Middle, Last) <b>Sherman Conigland</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Jettie Taylor</b>			19a. Informant's Name/Relationship (Type, Print) <b>Joseph H. Stokes, Jr.</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21236</b> <b>21 Wolfe Trappe Court Baltimore, Maryland</b>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>			20c. Location - City or Town, State <b>MD.</b>		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>WM.C.March FH 1101 E.North Avenue</b>			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Sepsis</b> Due to (or as a consequence of): <b>b. End Stage Renal Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b>		
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)			28b. Time of Injury <b>M</b>			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>D47746</b>		
29d. Date signed (Month, Day, Year) <b>February 16, 1999</b>			30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR Thomas Burke 9000 Franklin Square DR. Baltimore, Maryland 21237</b>			31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		
32. Registrar's Signature 			33. Registrar's Title <b>G. Sparks</b>			34. Registrar's Office <b>Baltimore, Maryland</b>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04958

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

STANLEY

SHANKS

2. Date of Death

February 15 1999

3. Time of Death

2:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

218-46-9794

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

03-01-48

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3708 Erdman Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

High Sch. Grad

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

unemployed

17. Father's Name (First, Middle, Last)

Clifton

Hill

18. Mother's Name (First, Middle, Maiden Surname)

Eunice

Shanks

19a. Informant's Name/Relationship (Type, Print)

Tarsha Shanks

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5626 Whitby Road Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell MEM. Gardens

Date

02-22-99 Dundalk, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Pneumonia

b.

Due to (or as a consequence of):

HIV Disease

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

ANURAG GUPTA M.D.

29c. License number

P 12561

29d. Date signed (Month, Day, Year)

15 February 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANURAG GUPTA 601 LOCH RAVEN BOULEVARD BALTIMORE, MD - 21239

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04959

Items: 20a,b,c per F.H G-769 3/5/99 reb

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joseph M. Stuart</b>				2. Date of Death Month <b>February</b> Day <b>18</b> Year <b>1999</b>		3. Time of Death <b>1:10 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Randallstown Genesis Eldercare</b>				4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>216-12-9246</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 9, 1923</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4009 Liberty Heights Ave</b>				10f. Zip Code		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Merchant Seaman</b>			16b. Kind of Business/Industry <b>Steamship</b>	
17. Father's Name (First, Middle, Last) <b>Harry L. Stuart</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marjorie Norford</b>				
19a. Informant's Name/Relationship (Type, Print) (Caregiver) <b>Mrs. Mary Washington</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4009 Liberty Heights Ave. Balto, Md.</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Cem.</b>		Date <b>3/10/99</b>		20c. Location - City or Town, State <b>Owings Mills, Md.</b>		
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>								Approximate Interval Between Onset and Death <b>YRS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEIZURES</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Kenneth M. Zimm</b>		29c. License number <b>D20333</b>		29d. Date signed (Month, Day, Year) <b>2/19/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R. ZIMMERMAN MD 1838 ANTHEM RD PINEVILLE MD 21228</b>								
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <b>Benita B. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04960

AMEND ITEM: #23B PE MD G774 8-4-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LAWRENCE HOWARD SCHRIEFER</b>				2. Date of Death Month Day Year <b>February 12 1999</b>		3. Time of Death <b>9:31 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>215-10-5045</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 6, 1915</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>CHASS</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>7001 R20 BIRD ROAD</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W-II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7 YRS</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OUTSIDE MACHINIST</b>		16b. Kind of Business/Industry <b>MARYLAND SHIPYARD AND DRY DOCK</b>				
	17. Father's Name (First, Middle, Last) <b>JOHN L. SCHRIEFER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CAROLINE BUSCH</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>HOWARD L. SCHRIEFER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4311 WEBSTER LAPIDUM ROAD</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>DULANY VALLEY</b>		Date <b>FEB. 16 1999</b>		20c. Location - City or Town, State <b>TIMONIUM, MARYLAND</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>EVANS CHARLOTTES 2325 YORK ROAD TIMONIUM, MARYLAND 21093</b>				
	23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pulmonary Edema and Congestion</b> Due to (or as a consequence of): <b>b. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):							Approximate Interval Between Onset and Death <b>2 Weeks</b> <b>10 Years</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Dr. Babak Imanol</b>		29c. License number <b>RD 185348</b>		29d. Date signed (Month, Day, Year) <b>February 12, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Babak Imanol, 9000 Franklin Square Drive, Baltimore, Maryland 21237</b>									
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature 							

SCHRIEFER, Lawrence H.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Amended#23apt1D PERPhyG768 2/25/99 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EVELYN MAY SCHOENIG</b>				2. Date of Death Month <b>FEB</b> Day <b>17</b> Year <b>1999</b>		3. Time of Death <b>7:50 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>GENESIS ELDERCARE - LOCH RAVEN CTR.</b>				4b. City, Town, or Location of Death <b>PARKVILLE</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>212-20-4763</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 4, 1916</b>	9. Birthplace (State or Foreign Country) <b>MD.</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PERRY HALL</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>3708 E. JOPPA ROAD</b>				10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOME MAKER</b>		16b. Kind of Business/Industry <b>AT HOME</b>			
17. Father's Name (First, Middle, Last) <b>CLIFTON MONROE TEAL</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>EDNA PEARL SHANKLIN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>NANCY HIGH, DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>816 CHATFIELD RD. JOPPATOWN, MD. 21085</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MORELAND MEM. PK.</b>		Date <b>FEB. 11, 1999</b>		20c. Location - City or Town, State <b>PARKVILLE, MD.</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES 8800 HARFORD RD. PARKVILLE, MD. 21234</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. <b>Severe Anemia</b> Due to (or as a consequence of): b. <b>Esophageal Variceal Bleeding</b> Due to (or as a consequence of): c. <b>Cirrhosis of Liver</b> Due to (or as a consequence of): d. <b>AUTOIMMUNE HEPATITIS</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D25569</b>		29d. Date signed (Month, Day, Year) <b>FEB. 18, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. FRANCIS L. WIEGMANN 1205 YORK RD. BALTIMORE, MD. 21093</b>									
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Item: 1 per M.D G-768 2/19/99 reb

Certificate of Death

Reg. No.

99 04962

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Frieda FRIEDA A. Sieck</b>				2. Date of Death Month <b>Feb.</b> Day <b>15</b> Year <b>1999</b>		3. Time of Death <b>8:50A.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>Ridgeway Manor</b>				4b. City, Town, or Location of Death <b>Catonsville</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>216-30-8465</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>97</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10/12/1901</b>	
9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>Md</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>107 Cherrydell Road</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 3</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>William Henry Schaper</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Kappauf</b>		19a. Informant's Name/Relationship (Type, Print) <b>Gertrude Sieck/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>107 Cherrydell Road, Balto, Md. 21228</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		Date <b>2/18/99</b>		20c. Location - City or Town, State <b>Baltimore, Md</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic Breast Cancer</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>1 year</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number <b>023365</b>		29d. Date signed (Month, Day, Year) <b>2/15/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Patrick W. White MD 716 Maiden Lane #205, Baltimore, MD 21228</b>							
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature 			

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04963

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Ann Smith				2. Date of Death Month Day Year February 17, 1999				3. Time of Death 12:44 P.M.				
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale				4c. County of Death BALTIMORE				
Funeral Director	5. Social Security Number 212-40-0667		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 9, 1941		9. Birthplace (State or Foreign Country) Virginia				
	Usual Residence of Decedent												
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 645 Dunwich Way				10f. Zip Code 21221				10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Years Collage (1-4or 5+) 10 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress				16b. Kind of Business/Industry Food Service					
17. Father's Name (First, Middle, Last) Fred Mills						18. Mother's Name (First, Middle, Maiden Summa) Annie Lovell							
19a. Informant's Name/Relationship (Type, Print) Daughter Mrs. Patricia S. Jones						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12906 Bogby Road Middle River, Maryland 21220							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. 2/19/1999				20c. Location - City or Town, State Towson, Maryland					
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. <u>Myocardial Infarction</u> Dua to (or as a consequence of):</p> <p>b. <u>CORONARY ARTERY DISEASE</u> Dua to (or as a consequence of):</p> <p>c. _____ Dua to (or as a consequence of):</p> <p>d. _____ Dua to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>7 DAYS</p> </div> </div>													
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  <u>Renal Failure</u>  <u>Diabetes Mellitus</u>													
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i> MD				29c. License number RD191981		29d. Date signed (Month, Day, Year) February 17, 1999			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) VIRESH N. PATEL, MD; 9000 FRANKLIN SQUARE DRIVE; BALTIMORE, MD 21237													
31. Date filed (Month, Day, Year) FEB 19 1999				32. Registrar's Signature <i>[Signature]</i>									

To Be Completed by Funeral Director

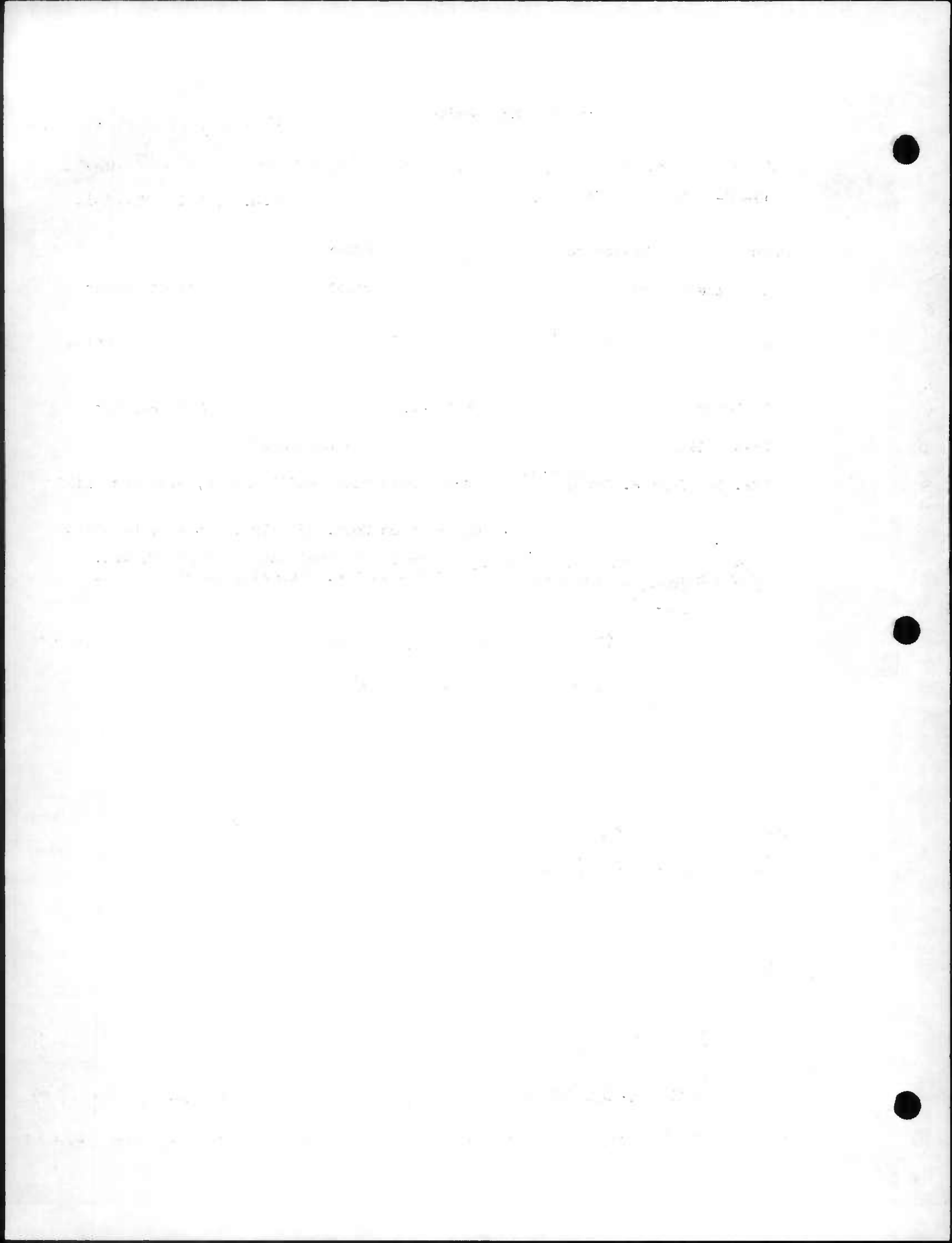
Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04964

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Rita Shaff				2. Date of Death Month Day Year February 12 1999				3. Time of Death 5:00PM	
	4a. Facility Name (If not Institution, give street and number) St. Joseph Medical Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-20-1292		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) April 19 1925		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD.		10b. County Baltimore		10c. City, Town or Location Glen Arm				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 12813 Dulaney Valley Rd.				10f. Zip Code 21057		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Bernard C. Miller				18. Mother's Name (First, Middle, Maiden Surname) Mildred L. Vinup					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Robert M. Shaff/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12813 Dulaney Valley Rd. Glen Arm, Md. 21057					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Cemetery		Date 2-16-99		20c. Location - City or Town, State Timonium, MD.	
	21. Signature of Funeral Service Licensee Michael P. Ruff				22. Name and Address of Facility Ruck Towson Funeral Home, Inc 1050 York Rd. Towson, MD. 21204					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute Cardiac arrest</i> Due to (or as a consequence of): b. <i>CAD</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c. <i>S/P CABG angiotomy</i> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 5 yr 1 yr									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier F. SAUZARON				29c. License number D00607		29d. Date signed (Month, Day, Year) 2/15/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F. SAUZARON 3346 PAPER MILL RD, PHOENIX AZ 85031										
31. Date filed (Month, Day, Year) FEB 19 1999				32. Registrar's Signature Benita G. Sparks						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04965

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Milton Robert Seiler, Sr.				2. Date of Death Month Day Year Feb. 15, 1999				3. Time of Death 11:50pm		
	4a. Facility Name (If not institution, give street and number) Frederick Villa Nursing Home				4b. City, Town, or Location of Death Catonsville				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 215-05-2644		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) May 25, 1914		9. Birthplace (State or Foreign Country) Maryland								
Usual Residence of Decedent											
10a. State MD		10b. County Howard		10c. City, Town or Location Ellicott City				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 9302 Millbrook Road				10f. Zip Code 21042				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner				16b. Kind of Business/Industry Hardware			
17. Father's Name (First, Middle, Last) Albert Seiler					18. Mother's Name (First, Middle, Maiden Surname) Johanna Koeblitz						
19a. Informant's Name/Relationship (Type, Print) Doris Seiler (Wife)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9302 Millbrook Road, Ellicott City, MD 21042						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 2/18/99		20c. Location - City or Town, State Woodlawn, Maryland			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 15 minutes		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. UPPER RESPIRATORY INFECTION, PARKINSONS DISEASE WITH DEMENTIA								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				26a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 				29c. License number 022114				29d. Date signed (Month, Day, Year) FEBRUARY 16, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAMIAN E. BIRCHNESS MD 5411 OLD FREDERICK ROAD, SUITE 18, BALTIMORE, MARYLAND 21209											
31. Date filed (Month, Day, Year) FEB 19 1999				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04966

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Willard Scott Spears Sr.</b>				2. Date of Death Month Day Year <b>February 16 1999</b>		3. Time of Death <b>10:54 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-12-5585</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct 7, 1920</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>2634 Liberty Parkway</b>			10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Draftsman</b>			16b. Kind of Business/Industry <b>Beth - Steel</b>		
	17. Father's Name (First, Middle, Last) <b>Walter Scott Spears</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruby Estelle Bowers</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Emily Spears /wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2634 Liberty Parkway Baltimore, MD 21222</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial</b>		Date <b>Feb 19 1999</b>		20c. Location - City or Town, State <b>Bel Air, MD</b>	
	21. Signature of Funeral Service Licensee <i>Anthony Colt Connelly</i>				22. Name and Address of Facility <b>Connolly Funeral Home of Dundalk 7110 Sollers Point Rd 21222</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Sepsis</b> Due to (or as a consequence of): <b>Chronic obstructive pulmonary disease</b> Due to (or as a consequence of): <b>Left Ventricular dysfunction</b> Due to (or as a consequence of):							Approximate Interval Between Onset and Death <b>1-2 days</b> <b>4 years</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D44793</b>		29d. Date signed (Month, Day, Year) <b>2-17-99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ali Sanai M.D. 6730 Holabird Ave Baltimore, MD 21222</b>								
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

KATHYRN THOMPSON February 15, 1999 3:30 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Kathryn Rebecca Thompson</b>						2. Date of Death Month <b>Feb.</b> Day <b>15</b> Year <b>1999</b>		3. Time of Death <b>3:30 pm</b>	
4a. Facility Name (If not Institution, give street and number) <b>Stella Maris</b>				4b. City, Town, or Location of Death <b>Timonium</b>		4c. County of Death <b>Baltimore</b>			
5. Social Security Number <b>217-36-4150</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 16 1911</b>		9. Birthplace (State or Foreign Country) <b>PA</b>	
Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Freeland</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>19606 Spook Hill Road</b>				10f. Zip Code <b>21053</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registered Nurse</b>			16b. Kind of Business/Industry <b>Health Care</b>		
17. Father's Name (First, Middle, Last) <b>Martin Wayne Sagner</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Agnes Alberts</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Armstead Thompson/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19606 Spook Hill Road, Freeland, MD 21053</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens</b>		Date <b>2/19/99</b>		20c. Location - City or Town, State <b>Timonium, MD</b>			
21. Signature of Funeral Service Licensee <b>Lowell M. Lemmon</b>				22. Name and Address of Facility <b>Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Congestive Heart Failure</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D43725</b>		29d. Date signed (Month, Day, Year) <b>2/16/99</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>									
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature <b>[Signature]</b>					



## Certificate of Death

Reg. No.

99 04968

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Jarrett D. Toboll</u>				2. Date of Death Month Day Year <u>FEB. 13, 1999</u>		3. Time of Death <u>0240 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>2202 AQUILAS DELIGHT ROAD</u>				4b. City, Town, or Location of Death <u>FALLSTON</u>		4c. County of Death <u>HARFORD</u>	
Funeral Director	5. Social Security Number <u>218-15-4798</u>	6. Sex <u>1</u> M <u>2</u> F	7. Age (in yrs. last birthday) <u>16</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>March 17, 1982</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>
	Usual Residence of Decedent							
10a. State <u>Md</u>		10b. County <u>Harford</u>		10c. City, Town or Location <u>Fallston</u>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <u>2202 Aquilas Delight</u>				10f. Zip Code <u>21047</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9 yrs</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>landscaper</u>		16b. Kind of Business/Industry <u>Gene's Evergreen</u>		
17. Father's Name (First, Middle, Last) <u>George J. Toboll</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Janice N. Kile</u>				
19a. Informant's Name/Relationship (Type, Print) <u>George J. Toboll - father</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2202 Aquilas Delight Fallston, Md 21047</u>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Evans Funeral Chapel - Bel Air</u>		Date <u>Feb. 15 1999</u>		20c. Location - City or Town, State <u>Forest Hill, Maryland</u>		
21. Signature of Funeral Service Licensee <u>Heidi S. Wells</u>				22. Name and Address of Facility <u>Evans Funeral Chapel - Bel Air</u> <u>3 Newport Dr. Forest Hill, Md 21050</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of): <u>Shotgun wound of head</u>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <u>2-13-99</u>		28b. Time of Injury <u>Found 0120 M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <u>Subject shot self</u>
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u>Residence</u>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>2202 Aquilas Delight Harford County, Maryland</u>				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <u>Stephen S. Radentz</u>						
		29c. License number <u>O.C.M.E</u>		29d. Date signed (Month, Day, Year) <u>FEB. 13, 1999</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</u>								
31. Date filed (Month, Day, Year) <u>FEB 19 1999</u>		32. Registrar's Signature <u>John A. Spahr</u>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04969

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Donald Edward Theborge</b>				2. Date of Death Month Day Year <b>Feb. 11 1999</b>		3. Time of Death <b>9:53 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>232 Endsleigh Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore County</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>214-20-8072</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 10, 1926</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore County</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>232 Endsleigh Avenue</b>		10f. Zip Code <b>21220</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates <b>Korean</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 yrs.</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>		16b. Kind of Business/Industry <b>Food Industry</b>		
17. Father's Name (First, Middle, Last) <b>Joseph Theborge</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mae Higgins</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Donna M. Nicosia</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>766 Shore Drive Joppa, Maryland 21015</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery</b>		Date <b>2-16-98</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lassahn Funeral Home</b> <b>7401 Belair Rd. Baltimore, Md. 21236</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Coronary artery disease</b> Due to (or as a consequence of): <b>Hypertensive atherosclerosis</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>1. Hypertensive atherosclerosis</b> <b>2. Coronary artery disease</b> Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>years</b> <b>year</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D18048</b>		29d. Date signed (Month, Day, Year) <b>Feb 12, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Louis O. Olsen 1012 S. W. St. Baltimore 21224</b>								
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature 						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04970

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIOLET C. TURNER</b>				2. Date of Death Month Day Year <b>FEB 13, 1999</b>		3. Time of Death <b>1:18 PM</b>																							
	4a. Facility Name (If not institution, give street and number) <b>301 McMECHAN STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>																							
Funeral Director	5. Social Security Number <b>218-32-3313</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>NOV 9, 1907</b>																							
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>																							
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>301 McMECHAN STREET #1114</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>																								
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>																								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CATERER</b>		16b. Kind of Business/Industry <b>Self-Employed</b>																										
17. Father's Name (First, Middle, Last) <b>William Irving Chatman</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>SARAH Ella Nelson</b>																										
19a. Informant's Name/Relationship (Type, Print) <b>Marjorie Banks</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7202 CHALKSTONE DR. #B BALTIMORE, Maryland 21208</b>																										
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>DAVID RIDGE Cemetery</b>		20c. Location - City or Town, State <b>Pikesville, Maryland</b>		20d. Date <b>2-18-99</b>																								
21. Signature of Funeral Service Licensee <b>Gray Hair</b>				22. Name and Address of Facility <b>CHATMAN - HARRIS Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, Maryland 21215</b>																										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																														
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Coronary artery disease</b></td> <td>longstanding</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td><b>Hyperglycemia</b></td> <td>longstanding</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td><b>Hypercholesterolemia</b></td> <td>longstanding</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Coronary artery disease</b>	longstanding	Due to (or as a consequence of):			b.	<b>Hyperglycemia</b>	longstanding	Due to (or as a consequence of):			c.	<b>Hypercholesterolemia</b>	longstanding	Due to (or as a consequence of):			d.			
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Coronary artery disease</b>	longstanding																											
	Due to (or as a consequence of):																													
	b.	<b>Hyperglycemia</b>	longstanding																											
	Due to (or as a consequence of):																													
c.	<b>Hypercholesterolemia</b>	longstanding																												
Due to (or as a consequence of):																														
d.																														
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>None</b>																														
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																														
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																												
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>N/A</b>		28b. Time of Injury <b>N/A</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>N/A</b>																								
28d. Describe how injury occurred <b>N/A</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>N/A</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>																										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																														
29b. Signature and title of certifier <b>D.R. Martin MD</b>				29c. License number <b>Maryland D40897</b>		29d. Date signed (Month, Day, Year) <b>2/17/99</b>																								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DON R. MARTIN, MD JHOC Rm # 7143 601 N. CAROLINE ST. BALT. MD 21287</b>																														
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature <b>[Signature]</b>																										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

99 04971

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SANTA TRIOLO</b>				2. Date of Death Month Day Year <b>FEBRUARY 17 99</b>		3. Time of Death <b>10 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>302 S. EXETER ST.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>2 19 - 26 - 9551</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85 Yrs.</b>		8. Date of Birth Month Day Year <b>NOV. 5, 1913</b>	
	9. Birthplace (State or Foreign Country) <b>W. VIRGINIA</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>302 S. EXETER ST.</b>		10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>				
17. Father's Name (First, Middle, Last) <b>VINCENZO GENOVESE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA PRESCIMONE</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Carmela Serafini (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1404 ROSEWICK AVE BALTO 21237 MD.</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ENTOMBMENT HOLY REDEEMER CH.</b>		20c. Location - City or Town, State <b>BALTO. MD.</b>		20d. Date <b>2/18/99</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DELLA NOCCE SONS FUNERAL HOME 322 S. HIGH ST. BALTO 21202 MD.</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PARKINSON'S DISEASE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death <b>6 YRS</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D38 033</b>		29d. Date signed (Month, Day, Year) <b>2/18/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>IRENE D. BAIRD 261 S. HIGHLAND AVE BALTO. MD 21224</b>								
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature 						

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #17 PER F.H. G768 2-19-99 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Francis Volz</b>				2. Date of Death Month Day Year <b>February 18, 1999</b>		3. Time of Death <b>10:55 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>FRANKLIN SQUARE Hospital Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>216-01-4028</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 23 1915</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>6116 Belair Road</b>		10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>U.S. of America</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942 1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Chemical Engineer</b>		16b. Kind of Business/Industry <b>U.S. Government</b>					
17. Father's Name (First, Middle, Last) <b>William JOHN Volz</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Durham</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Catherine S. Volz (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>524 N. Charles St. Balto., Md. 21201 Apt. 1311</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>					
21. Signature of Funeral Service Licensee <i>Mark A. Chojnacki</i>				22. Name and Address of Facility <b>W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Balto., Md. 21224</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Aspiration Pneumonia Severe</b> Due to (or as a consequence of): b. <b>Duodenal Ulcer</b> Due to (or as a consequence of): c. <b>Myocardial Infarction</b> Due to (or as a consequence of): d. <b>Pseudomembranous colitis</b>								Approximate Interval Between Onset and Death <b>5 DAYS</b> <b>2 DAYS</b> <b>2 DAYS</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Daniel Alexander MD</i>		29c. License number <b>RD 187286</b>		29d. Date signed (Month, Day, Year) <b>February 18, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. DANIEL ALEXANDER 9000 FRANKLIN SQUARE DR. BALTIMORE, MARYLAND 21237</b>									
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <i>Beverly B. Sparks</i>							

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04973

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Marie Alice Walter</b>				2. Date of Death Month Day Year <b>February 16, 1999</b>		3. Time of Death <b>7:12 a.m.</b>	
4a. Facility Name (If not institution, give street and number) <b>Holy Cross Nursing Home</b>				4b. City, Town, or Location of Death <b>Burtonsville</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>577-24-8043</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 20, 1918</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Burtonsville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3700 Bell Road</b>				10f. Zip Code <b>20866</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Line Worker</b>		16b. Kind of Business/Industry <b>Manufacturing</b>	
17. Father's Name (First, Middle, Last) <b>Ezra Fowler</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Mary Muldoon</b>			
19a. Informant's Name/Relationship (Type, Print) <b>James R. Smith, Jr./Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8504 Churchhill Court, Upper Marlboro, MD 20772</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		20c. Date <b>2/19/99</b>		20d. Location - City or Town, State <b>Brentwood, Maryland</b>	
21. Signature of Funeral Service Licensee <i>James R. Smith</i>				22. Name and Address of Facility <b>Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Coronary Heart Failure</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arteriosclerotic Cardiovascular Disease</b>							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Myron L. Lenken</i>				29c. License number <b>006674</b>		29d. Date signed (Month, Day, Year) <b>2/18/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MYRON L. LENKEN MD 2309 SHOREFIELD RD WHEATON MD 20902</b>							
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature <i>B. Sparks</i>			

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

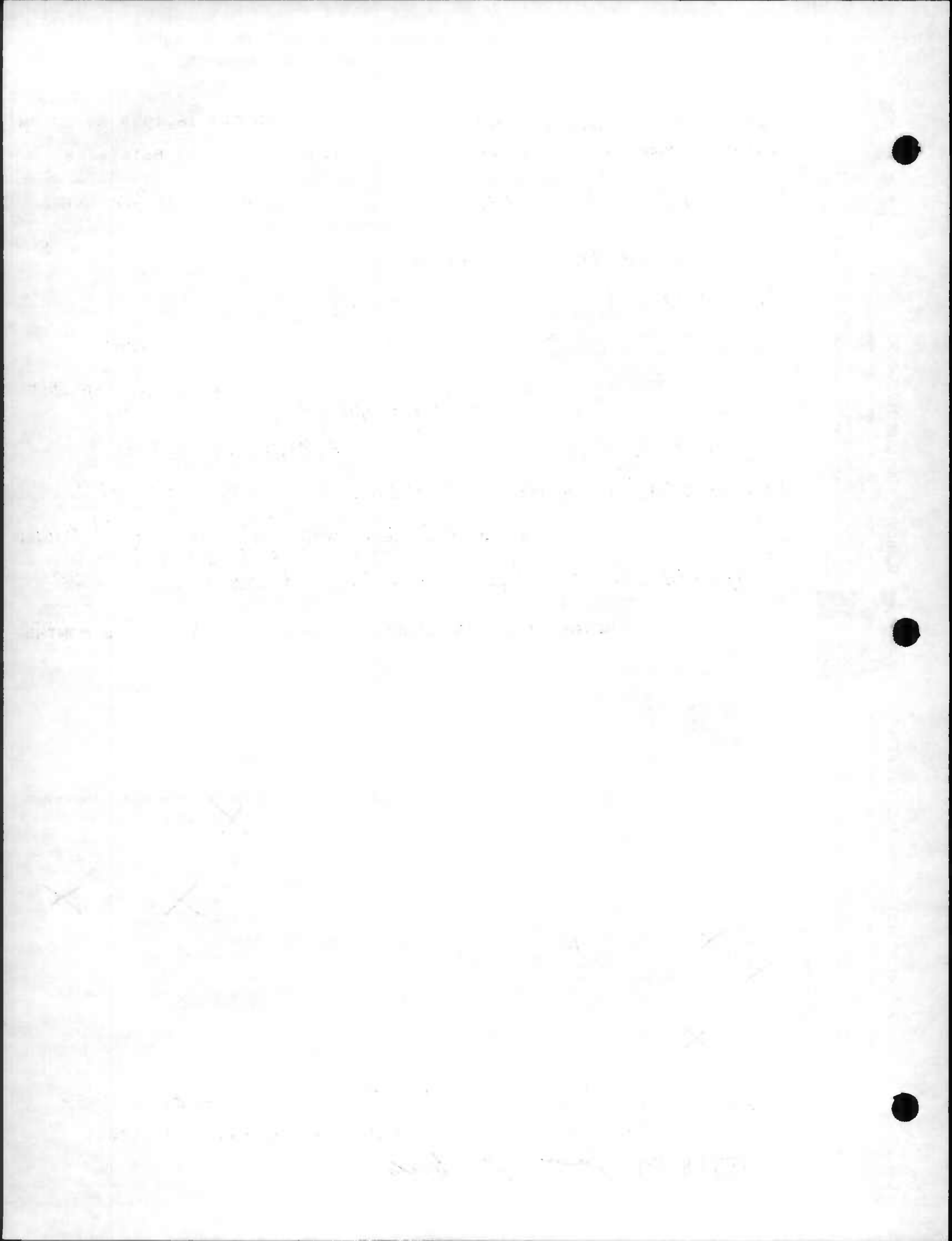
89 04974

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Margaret Suzanne Walters</i>		2. Date of Death Month <i>FEBRUARY</i> Day <i>16</i> Year <i>1999</i>		3. Time of Death <i>09:25 PM</i>
	4a. Facility Name (If not institution, give street and number) <i>Saint Joseph Medical Center</i>		4b. City, Town, or Location of Death <i>Towson</i>		4c. County of Death <i>Baltimore</i>
Funeral Director	5. Social Security Number <i>217-56-6733</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>60</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month, Day, Year <i>Sept. 1, 1938</i>		9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10a. State <i>Md</i>	10b. County <i>Baltimore</i>	10c. City, Town or Location <i>Parkville</i>		
	10e. Street and Number <i>5 McKenna Ct.</i>		10f. Zip Code <i>21234</i>		10g. Citizen of What Country? <i>USA</i>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>1</i>		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>tooling inspector</i>		16b. Kind of Business/Industry <i>Middle River Aircraft Systems</i>	
17. Father's Name (First, Middle, Last) <i>John E. Kunkle</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Alberta J. Cottle</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Monica Dvorak daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>21 Tameron Place Baltimore, Md 21237</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Dulaney Valley Mem. Gardens</i>		20c. Location - City or Town, State <i>Timonium, Maryland</i>	
21. Signature of Funeral Service Licensee <i>Krista S. Wells</i>		22. Name and Address of Facility <i>EVANS Chapel of Memories 8800 Harford Rd. Baltimore, Md 21234</i>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <i>METASTATIC LUNG CANCER</i>				Approximate Interval Between Onset and Death <i>2 MONTHS</i>
	a. Due to (or as a consequence of):				
	b. Due to (or as a consequence of):				
	c. Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Beatriz P. Dizon, M.D.</i>		29c. License number <i>D 16492</i>		29d. Date signed (Month, Day, Year) <i>Feb. 16, 1999</i>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>BEATRIZ P. DIZON, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204</i>					
31. Date filed (Month, Day, Year) <i>FEB 19 1999</i>		32. Registrar's Signature <i>B. Sparks</i>			

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

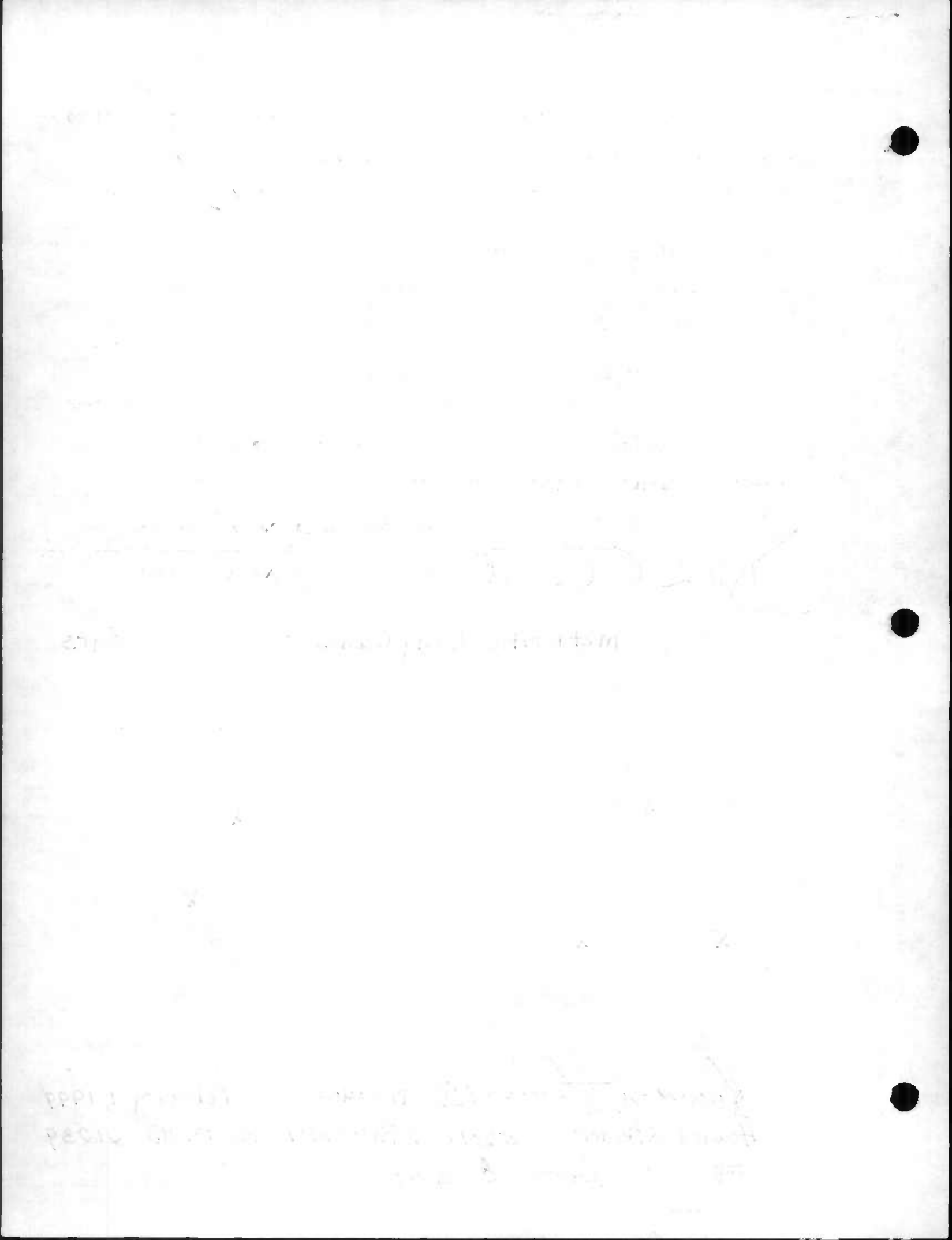
State of Maryland / Department of Health and Mental Hygiene 99 04975

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frank Joseph Wasowicz				2. Date of Death Month Day Year February 9, 1999		3. Time of Death 10:20 AM	
	4e. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-18-7872	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	8. Date of Birth (Month, Day, Year) 02/04/1923	9. Birthplace (State or Foreign Country) MD.			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.	10b. County Baltimore	10c. City, Town or Location Towson		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 707 Shelley Rd.		10f. Zip Code 21286		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lawyer		16b. Kind of Business/Industry State of Maryland			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Alexander Wasowicz				18. Mother's Name (First, Middle, Maiden Surname) Amelia Malanowski			
	19e. Informant's Name/Relationship (Type, Print) Lorraine C. Wasowicz (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Shelley Rd. Towson, MD. 21286			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park Dulaney Valley Mem. Grdns.		20c. Location - City or Town, State Parkville Timonium, MD.		20d. Date 2/12/99	
	21. Signature of Funeral Service Licensee Dennis C. Carroll				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204			
Physician /Medical Examiner	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>metastatic Lung Cancer</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 3 yrs
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier Howard Steiner MD				29c. License number D38403		29d. Date signed (Month, Day, Year) February 9, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Steiner 5601 Loch Raven Blvd Balto. MD 21239							
	31. Date filed (Month, Day, Year) FEB 19 1999		32. Registrar's Signature B. Sparks					

ORIGINAL





WRC  
99-0828-510  
MARGARET  
WISEMAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

99 04976

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>MARGARET A. WISEMAN</b>		2. Date of Death Month Day Year <b>FEB. 13, 1999</b>		3. Time of Death <b>3:38 PM.</b>	
4a. Facility Name (If not institution, give street and number) <b>3810 LYNDAL AVE.</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>212-26-9491</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>FEB. 7, 1929</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>			
10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3810 LYNDAL AVENUE</b>		10f. Zip Code <b>21213</b>	
10g. Citizen of What Country? <b>U. S. A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) <b>12TH GRADE</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		17. Father's Name (First, Middle, Last) <b>JOHN LIPP</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>MARY McCART</b>		19a. Informant's Name/Relationship (Type, Print) <b>MRS. ALICE KOESTER (SISTER-IN-LAW)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4718 WHITE MARSH ROAD, BALTIMORE, MARYLAND 21237</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARDENS OF FAITH</b>		20c. Location - City or Town, State <b>2/20/99 BALTIMORE, MARYLAND</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SCHIMUNEK FUNERAL HOME INC. 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <b>INSPECTION</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>Stephen Radentz, M.D.</b>		29c. License number <b>O.C.M.E.</b>	
29d. Date signed (Month, Day, Year) <b>FEB. 14, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>		31. Data filed (Month, Day, Year) <b>FEB 19 1999</b>	
32. Registrar's Signature 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04977

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Gail V Williams</u>				2. Date of Death Month <u>February</u> Day <u>Sixteenth</u> Year <u>1999</u>				3. Time of Death <u>8:15 A.M.</u>		
	4a. Facility Name (If not institution, give street and number) <u>University of Maryland Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>				4c. County of Death <u>Baltimore City</u>		
Funeral Director	5. Social Security Number <u>219-62-5441</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>43</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>August 2, 1955</u>		9. Birthplace (State or Foreign Country) <u>MARYLAND</u>		
	10a. State <u>MD</u>				10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <u>5042 Clifton Ave.</u>				10f. Zip Code <u>21207</u>		10g. Citizen of What Country? <u>U.S.A.</u>					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>2 yrs.</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>CLERK</u>				16b. Kind of Business/Industry <u>OFFICE</u>			
17. Father's Name (First, Middle, Last) <u>Joseph Williams</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Gertrude Savage</u>							
19a. Informant's Name/Relationship (Type, Print) <u>Denise Eskew - Sister</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5042 Clifton Ave. Balto., MD 21207</u>							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>King Memorial Park</u>			20c. Location - City or Town, State <u>220-99 Randallstown, MD</u>					
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>East Frederick Funeral Home, PA</u>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>a. Pneumonia</u> Due to (or as a consequence of): <u>b. Acquired Immunodeficiency Syndrome</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <u>3 days</u> <u>five years</u>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Cryptococcal Meningitis</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>Scott Whittaker M.D.</u>				29c. License number <u>P12510</u>		29d. Date signed (Month, Day, Year) <u>February sixteenth, 1999</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Scott Whittaker 159 West Pratt Street Apartment # 316, Baltimore, MD 21201</u>											
31. Date filed (Month, Day, Year) <u>FEB 19 1999</u>				32. Registrar's Signature <u>[Signature]</u>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 99 04978

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alice B. Williams

2. Date of Death

February 7, 1999

3. Time of Death

5a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Windsor Ridge Nursing Rehabilitation Center

4b. City, Town, or Location of Death

n/a

4c. County of Death

Baltimore

5. Social Security Number

034-05-9836

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

97

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 4, 1902

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

318 Wellham Avenue

10f. Zip Code

21061-2154

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private Families

17. Father's Name (First, Middle, Last)

George Berry

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Warner

19a. Informant's Name/Relationship (Type, Print)

Gilbert G. Brooks nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

318 Wellham Avenue Glen Burnie, Md. 21061-2154

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

New Cathedral Cemetery

Date

Feb. 12

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.

2501 Gwynns Falls PKWY Baltimore, Md. 21216

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Chronic Renal FAILURE

Due to (or as a consequence of):

Atherosclerotic Vascular Disease

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Congestive heart Failure

Advanced Age.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

R. Liberty, M.D.

29c. License number

D2146x

29d. Date signed (Month, Day, Year)

2/11/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ROBERT LIBERTO, M.D. 3508 BANK ST 21224

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be dated for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

89 04979

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jeffrey Kevin Williams

2. Date of Death

February 17, 1999

3. Time of Death

7:45 am

4a. Facility Name (If not institution, give street and number)

Saint Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-96-2080

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

34 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar 23, 1964

9. Birthplace (State or Foreign)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7912 Mainfalls Circle

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

County Police Detective

16b. Kind of Business/Industry

LAW Enforcement

17. Father's Name (First, Middle, Last)

Paul Lawrence Williams

18. Mother's Name (First, Middle, Maiden Surname)

Carrietta Smith

19a. Informant's Name/Relationship (Type, Print)

Vera J. Williams (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7912 Mainfalls Circle Catonsville, Md 21228

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Pk

Date

2/22/99 Arbutus, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Caple Funeral Service

5502 Winner Avenue Baltimore, Md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Choriocarcinoma

Approximate Interval Between Onset and Death

1 week

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24e. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No25. Was case referred to medical examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D47380

29d. Date signed (Month, Day, Year)

February 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. David P. Frishberg - St. Agnes HealthCare - 900 Caton Avenue - Baltimore, MD. / 21229

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: WILLIAMS, JEFFREY

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04980

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Elizabeth Waugh				2. Date of Death Month Day Year February 12, 1999		3. Time of Death 9:45am		
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 220-52-6260		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) 1/11/1916		
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent		10a. State MD		10b. County Baltimore		
10c. City, Town or Location Essex		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2225 Vailthorn Road		10f. Zip Code 21220		10g. Citizen of What Country? U. S. A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) William DeBraufre		18. Mother's Name (First, Middle, Maiden Surname) Sadie Keene	
19a. Informant's Name/Relationship (Type, Print) Mary M. Brooks				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2225 Vailthorn Road Essex, Maryland 21220					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Cem.		Date 2/17/99		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee Doris M. Brooks				22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Acute Renal Failure Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 weeks					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dennis H. Odie MD		29c. License number RD 191833		29d. Date signed (Month, Day, Year) February 12, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Odie MD, 9000 Franklin Square Drive Baltimore, MD 21237		31. Date filed (Month, Day, Year) FEB 19 1999		32. Registrar's Signature P. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 16a,b per F.H G-768 2/24/99 reb

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Merton B. Wood				2. Date of Death Month Day Year FEBRUARY 15, 1999				3. Time of Death 9:50 AM						
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore						
Funeral Director	5. Social Security Number 213-36-6477		6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. Age (In yrs. last birthday) 59 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) 04-06-1939		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent														
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 2 Dutrow CT.				10f. Zip Code 21237				10g. Citizen of What Country? U.S.A.							
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Engineer ENGINEER				16b. Kind of Business/Industry NSA N.A.S.A. Space Center							
17. Father's Name (First, Middle, Last) Merton H. Wood				18. Mother's Name (First, Middle, Maiden Surname) Helen Burrows											
19a. Informant's Name/Relationship (Type, Print) Jami Winterling/Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Clam Shell La. Selbyville, DE 19975											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Roxana Cemetery				Date 2/18/99		20c. Location - City or Town, State Roxana, Delaware					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  METASTATIC LUNG CARCINOMA a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 2 MONTHS											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D36814		29d. Date signed (Month, Day, Year) 2/15/99					
30. Name and address of person who completed cause of death (Item 23a). Type, Print) DR. RICHARD L. HUSLIG, M.D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204															
31. Date filed (Month, Day, Year) FEB 19 1999				32. Registrar's Signature 											

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

SECRET

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 04982

Frank Walton

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 2065.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Frank J. Walton</b>		2. Date of Death Month <b>02</b> Day <b>12</b> Year <b>99</b>		3. Time of Death <b>6:55am</b>	
4a. Facility Name (If not Institution, give street and number) <b>Dulaney Towson Health Care Center</b>			4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>
5. Social Security Number <b>216-05-4422</b>	6. Sex <b>2</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 4, 1910</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>3411 Northway Drive</b>			10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S. A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Plant Foreman</b>		16b. Kind of Business/Industry <b>Concrete Block Co.</b>	
17. Father's Name (First, Middle, Last) <b>Frank Walton</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Paturzo</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Neillie M. Walton/Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3411 Northway Drive Baltimore, Maryland 21234</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		20c. Location - City or Town, State <b>2/15/99 Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CEREBROVASCULAR DISEASE</b> Due to (or as a consequence of): <b>b. HYPERTENSION</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D47945</b>		29d. Date signed (Month, Day, Year) <b>February 12 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Harris Aileen 3007 E Northern Parkway Baltimore MD 21214</b>					
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature 			





jlm

GERALD

WOOD ITEMS: #23 PART I, 27, 28A-F PER MEO G769 3-26-99

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04983

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gerald H. Wood IV</b>				2. Date of Death Month Day Year <b>FEBRUARY 16, 1999</b>				3. Time of Death <b>00:04 AM</b>		
	4e. Facility Name (If not institution, give street and number) <b>JOHN HOPKINS BAYVIEW HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>219-84-0053</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>22</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	Usual Residence of Decedent		10e. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>2758 Kirkleigh Rd</b>		10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>		16b. Kind of Business/Industry <b>School</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		17. Father's Name (First, Middle, Last) <b>Gerald H. Wood III</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Chiyon Yim</b>	
19e. Informant's Name/Relationship (Type, Print) <b>Jacqueline Wood /sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2758 Kirkleigh Rd Baltimore, MD 21222</b>							
20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>				Date <b>Feb 20 1999</b>		20c. Location - City or Town, State <b>Catonsville, MD</b>	
21. Signature of Funeral Service Licensee <b>Anthony Colt Connelly</b>				22. Name and Address of Facility <b>Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				e. <b>SEIZURE DISORDER</b> Due to (or as a consequence of):							
				b. <b>HEAD INJURIES, REMOTE</b> Due to (or as a consequence of):							
				c. Due to (or as a consequence of):							
				d. Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) <b>6-22-96</b>		28b. Time of Injury <b>11:30</b> P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>PASSENGER IN MOTOR VEHICLE/FIXED OBJECT IMPACT</b>	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>HIGHWAY</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>GETTYSBURG, PA</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>FEBRUARY 16, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>[Signature]</b>				111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature <b>[Signature]</b>							





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04984

Physician  
(Medical  
Examiner)

1. Decedent's Name (First, Middle, Last)

Margaret Zaccanelli

2. Date of Death

February 13, 1999

3. Time of Death

5:50pm.

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's Co.

5. Social Security Number

579-38-2539

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 6, 1931

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12176 Dove Circle

10f. Zip Code

20708

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Staff Accountant

16b. Kind of Business/Industry

Accounting Firm

17. Father's Name (First, Middle, Last)

Raymond Saunders

18. Mother's Name (First, Middle, Maiden Surname)

Helen Cooper

19a. Informant's Name/Relationship (Type, Print)

Ernest Zaccanelli/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12176 Dove Circle, Laurel, Maryland 20708

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

2/16/99

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Due to (or as a consequence of):

Acute cholecystitis

b.

Due to (or as a consequence of):

Cholelithiasis

c.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

d.

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

hours

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advance Age

Sepsis

Pancreatitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

K. Michael Figaro MD

D0052865

February 14, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

5268 Dawes Ave, Alexandria, VA 22311 K. Michael Figaro.  
M.D.

31. Date filed (Month, Day, Year)

FEB 19 1999

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
50538.

Physician  
(Medical  
Examiner)

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Division of Vital Records, P.O. Box 68760,

Margaret Louise Zaccanelli  
Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04985

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Suchnicki Zych</b>				2. Date of Death Month <b>February</b> Day <b>18</b> Year <b>1999</b>		3. Time of Death <b>8:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>503 S. Luzerne Ave.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-18-9995</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>11/04/1909</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>503 S. Luzerne Ave.</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Domestic</b>		
17. Father's Name (First, Middle, Last) <b>Peter Suchnicki</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Victoria Kowalski</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Marion J. Zych Jr. / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>503 S. Luzerne Ave. Baltimore, Md. 21224</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Rosary Cemetery</b>		Date <b>2/22/99</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Md. 21231</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Coronary Artery disease</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>10 years</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Colon Cancer</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 0021612</b>		29d. Date signed (Month, Day, Year) <b>February 19 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>VINCENT W. DelaGARZA MD 5505 Hopkins Bayview Circle Baltimore, MD 21224</b>								
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04986

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Judith Ann Ziegenfuss</b>				2. Date of Death Month <b>Feb.</b> Day <b>16</b> Year <b>1999</b>		3. Time of Death <b>1:15am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Gilchrist Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore Co.</b>	
Funeral Director	5. Social Security Number <b>125-28-6405</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 8, 1936</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>807 Shelley Road</b>				10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>1</b>				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Executive Secretary</b>		16b. Kind of Business/Industry <b>Engineering</b>		
17. Father's Name (First, Middle, Last) <b>Thomas John Gould</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marian Elizabeth Zeluff</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Edward M. Ziegenfuss</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>807 Shelley Road Towson, MD 21286</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cem. Crem.</b>		Date <b>2/17/99</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		
21. Signature of Funeral Service Licensee <i>John D. Mitchell IV</i>				22. Name and Address of Facility <b>Mitchell-Wiedefeld Home, Inc.</b> <b>6500 York Road, Baltimore, MD 21212</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Small cell lung Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>2 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>W. A. Riley</i>						
		29c. License number <b>D25285</b>		29d. Date signed (Month, Day, Year) <b>February 16, 1999</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>W. A. Riley GMC 6701 N. Charles St. Balto. md 2120x</b>								
31. Date filed (Month, Day, Year) <b>FEB 19 1999</b>		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04987

Amended Item #7, 2/11/99, E.T, WCHD

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>William Frances Armwood</u>						2. Date of Death Month <u>2</u> Day <u>5</u> Year <u>99</u>			3. Time of Death <u>4:19 p.m.</u>					
	4a. Facility Name (If not institution, give street and number) <u>404-D - Trinity Dr.</u>						4b. City, Town, or Location of Death <u>Salisbury, Md.</u>			4c. County of Death <u>Wicomico</u>					
Funeral Director	5. Social Security Number <u>213-14-7567</u>		6. Sex <u>1</u> M <u>2</u> F		7. Age (In yrs. last birthday) <u>75</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>6-7-23</u>		9. Birthplace (State or Foreign Country) <u>MD</u>						
	Usual Residence of Decedent														
10a. State <u>MD</u>		10b. County <u>Wicomico</u>		10c. City, Town or Location <u>Salisbury Md.</u>				10d. Inside City Limits <u>1</u> Yes <u>2</u> No							
10e. Street and Number <u>404-D - Trinity Dr.</u>				10f. Zip Code <u>21802</u>				10g. Citizen of What Country? <u>U.S.A.</u>							
11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No <u>1-7-43</u> If Yes, Give Year or Dates: <u>1-16-46</u>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>7th grade</u> College (1-4or 5+) <u>Custodian</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>High School</u>				16b. Kind of Business/Industry							
17. Father's Name (First, Middle, Last) <u>Earl Armwood</u>						18. Mother's Name (First, Middle, Maiden Surname) <u>Maggie Maddox</u>									
19a. Informant's Name/Relationship (Type, Print) <u>Valerie Armwood (Granddaughter)</u>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>32367 Costen Rd. Westover Md. 21871</u>									
20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Md. Veteran Cemetery</u>			20c. Date <u>2-11-99</u>		20d. Location - City or Town, State <u>Beulah, Md.</u>							
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <u>Bennie Smith Funeral Home</u> <u>PO Box 331 - Pocomoke City, Md 21851</u>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>METASTATIC LUNG CANCER</u>										Approximate Interval Between Onset and Death <u>6 MONTHS</u>					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No										24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No					
25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No										26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)					
27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No		28d. Describe how Injury occurred						
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier 		29c. License number <u>D 46962</u>		29d. Date signed (Month, Day, Year) <u>FEBRUARY 8, 1999.</u>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>M. SHIRAZI, M.D. 12137 ELM ST. PRINCESS ANNE MD 21853.</u>															
31. Date filed (Month, Day, Year) <u>FEB 11 1999</u>										32. Registrar's Signature 					

To Be Completed by Funeral Director

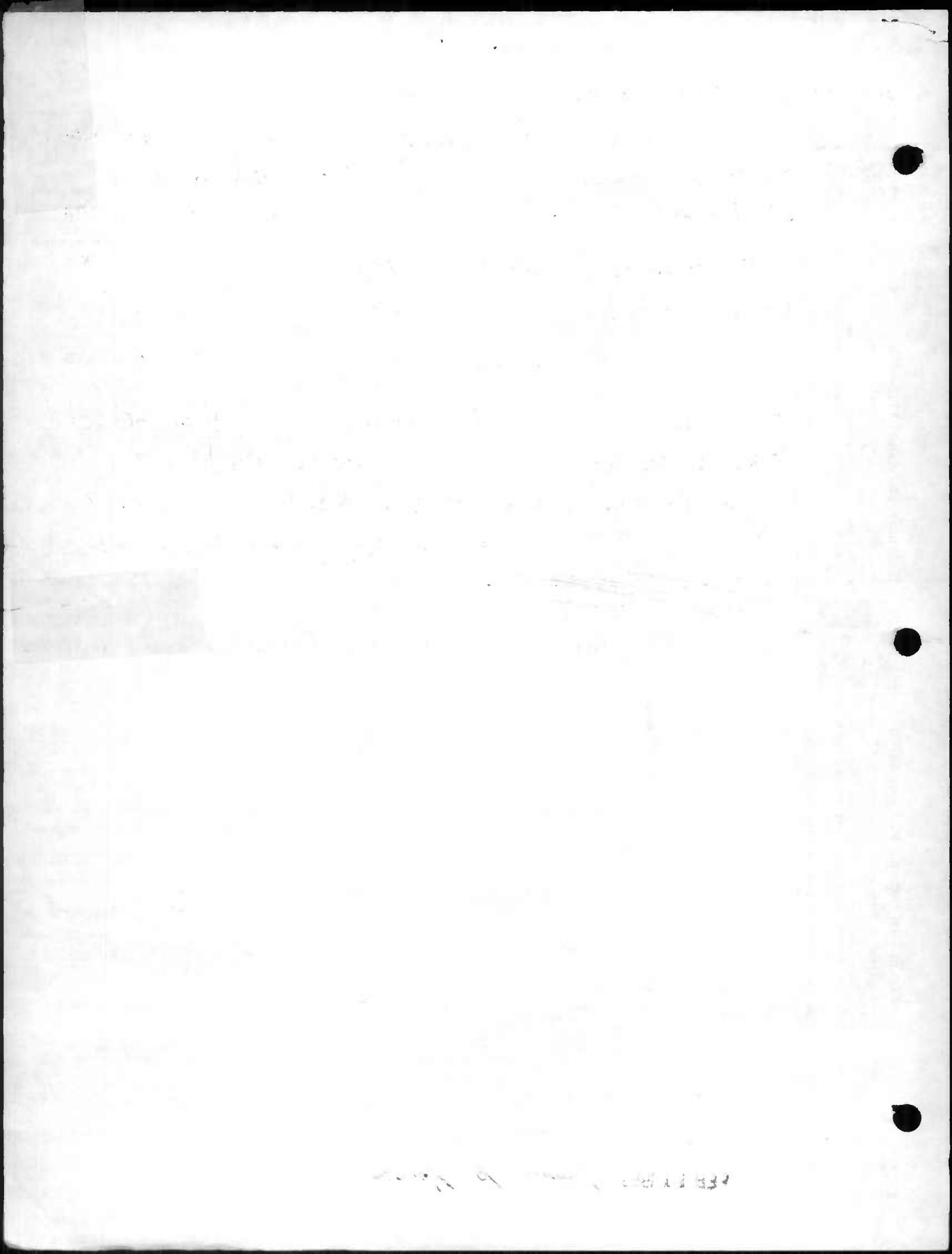
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



1931 1 1 1931

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

89 04988

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

WILLIAM St. JOHN BUELL, Sr.

2. Date of Death  
Month Day Year

January 29, 1999

3. Time of Death

4:00 a.m.

4a. Facility Name (If not Institution, give street and number)

P.O. Box 98

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Mary's

5. Social Security Number

073-22-9924

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

May 12, 1928

9. Birthplace (State or Foreign Country)

Bronx, NY

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Leonardtwn

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

P.O. Box 98

10f. Zip Code

20650

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Chef

16b. Kind of Business/Industry

Culinary

17. Father's Name (First, Middle, Last)

James Buell

18. Mother's Name (First, Middle, Maiden Surname)

Florence O'Brien

19a. Informant's Name/Relationship (Type, Print)

Phyllis F. Buell

wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 98, Leonardtown, MD 20650

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Charles Memorial Gardens

Date

2/1/99

20c. Location - City or Town, State

Leonardtwn, MD

21. Signature of Funeral Service Licensee

Ronald L. Thompson, Jr. #1154

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, MD 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic malignant Melanoma

Approximate Interval Between Onset and Death

1 month

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Avani Shah

29c. License number

D 47066

29d. Date signed (Month, Day, Year)

1-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avani Shah, M.D.

Leonardtwn, Maryland 20650

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 1 1999

32. Registrar's Signature

B. Apata

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04989

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

William Dunbar Boyd, Sr.

2. Date of Death  
Month Day Year

February 1, 1999

3. Time of Death

6:30 P.M.

4a. Facility Name (If not institution, give street and number)

37785 Chaptico Road

4b. City, Town, or Location of Death

Chaptico

4c. County of Death

St. Mary's

5. Social Security Number

579-40-7628

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
August 21, 1922

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Chaptico

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

37785 Chaptico Road

10f. Zip Code

20621

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1943-1948

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

8

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Medical Doctor

16b. Kind of Business/Industry

Medicine

17. Father's Name (First, Middle, Last)

George Washington Boyd

18. Mother's Name (First, Middle, Maiden Surname)

Mary Pearl Davis

19a. Informant's Name/Relationship (Type, Print)

Lorraine Boyd, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 247, Chaptico, Maryland 20621

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Joseph's Cemetery

Date

2-5-99

20c. Location - City or Town, State

Morganza, Maryland

21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr. M00052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.  
22955 Hollywood Road, Leonardtown, MD 2065023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *metastatic carcinoma*

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 mo

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *carcinoma prostate*

Due to (or as a consequence of):

2 yrs.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

John J. Fenwick

29c. License number

D01380

29d. Date signed (Month, Day, Year)

2-2-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Fenwick, M.D.

Leonardtown, Maryland 20650

31. Date filed (Month, Day, Year)

FEB 4 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-04990

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Norman Breslau				2. Date of Death Month Day Year FEBRUARY 06 1999				3. Time of Death 01:40 a.m.	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtwn				4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 023-14-7713	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 20, 1924		9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland	10b. County St. Mary's	10c. City, Town or Location Piney Point				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 45080 Lighthouse Road				10f. Zip Code 20674		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Veterinarian		16b. Kind of Business/Industry Animal Medicine					
	17. Father's Name (First, Middle, Last) Ben Breslau				18. Mother's Name (First, Middle, Maiden Surname) Edith Cohen					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ann Breslau, Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45080 Lighthouse Road, Piney Point, MD 20674					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Memorial		Data 2-8-99		20c. Location - City or Town, State California, Maryland			
	21. Signature of Funeral Service Licensee Michael K. Blankenship, M00857				22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARYTHMIA Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida		28a. Date of Injury (Month, Day, Year) 2-6-99		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number D-0052196				29d. Date signed (Month, Day, Year) 2-6-99		
29b. Signature and title of certifier J. Scott T. 2001/1, M.D.				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22335 Cypressville, Lexington Park MD				J. Scott T. 2001/1, M.D.		
31. Date filed (Month, Day, Year) FEB 8 1999				32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

BRESLAUER, NORMAN

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04991

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Josephine Badeaux				2. Date of Death Month Day Year February 9, 1999				3. Time of Death 12:30 PM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center				4b. City, Town, or Location of Death Leonardtown				4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 231-72-2169		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) April 2, 1913		9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Bushwood				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 21239 White Neck Road				10f. Zip Code 20618		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry N/A		
	17. Father's Name (First, Middle, Last) Andrew Jackson Copeland				18. Mother's Name (First, Middle, Maiden Surname) Clinnie P. Sawyer					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sidney E. Badeaux, Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 White Neck Road, Bushwood, Maryland 20618					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Date 2-10-99		20d. Location - City or Town, State Alexandria, Virginia			
	21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr. M00052				22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. End stage renal failure Due to (or as a consequence of): few weeks</p> <p>b. failure to thrive Due to (or as a consequence of): few weeks</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>									
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
					28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier A. Suah MD				29c. License number D 47066		29d. Date signed (Month, Day, Year) 2-10-99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani Shah, M.D. Leonardtown, Maryland 20650										
31. Date filed (Month, Day, Year) FEB 11 1999				32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 04992

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Maurice Ellsworth Barnhart</b>				2. Date of Death Month Day Year <b>February 4, 1999</b>		3. Time of Death <b>1342</b>	
	4a. Facility Name (If not institution, give street and number) <b>Julia Manor Health Care Center</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington County</b>	
Funeral Director	5. Social Security Number <b>214-05-6405</b>		6. Sex <b>10 M 20 F</b>		7. Age (In yrs. last birthday) <b>86 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Dec. 19, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Washington Co.</b> 10c. City, Town or Location <b>Hagerstown</b>		10d. Inside City Limits <b>10 Yes 20 No</b>			
10e. Street and Number <b>16917 Shady Brook Terrace</b>		10f. Zip Code <b>21740</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <b>10 Never Married 20 Married 30 Widowed 40 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>10 Yes 20 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>10 Yes 20 No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 11</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Stationary Engineer</b>		16b. Kind of Business/Industry <b>Leather Tannery</b>				
17. Father's Name (First, Middle, Last) <b>John Howard Barnhart</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Magdella McElroy</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mark Barnhart/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>945 Oak Hill Avenue, Hagerstown, Maryland 21742</b>				
20a. Method of Disposition <b>10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>		20c. Date <b>Feb. 5</b>		20d. Location - City or Town, State <b>Smithsburg, Maryland</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Lobes Pneumonia</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <b>10 Yes 20 No 30 Probably 40 Unknown</b>								
24a. Was an autopsy performed? <b>10 Yes 20 No</b>								
24b. Were autopsy findings available prior to completion of cause of death? <b>10 Yes 20 No</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease</b> <b>Lung Tumor</b>								
25. Was case referred to medical examiner? <b>10 Yes 20 No</b>		26. Place of Death (Check only one) Hospital: <b>10 Inpatient 20 ER/Outpatient 30 DOA</b> Other: <b>40 Nursing Home 50 Residence 60 Other (Specify)</b>		27. Manner of Death <b>10 Natural 20 Accident 30 Suicide 40 Homicide 50 Pending investigation 60 Could not be determined</b>		28. Date of Injury (Month, Day, Year) <b>Feb 4 1999</b>		
29a. Certifier (Check only one) <b>10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>026526</b>		29d. Date signed (Month, Day, Year) <b>2/5/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dino J. Delaportas, M.D., 11110 Medical Campus Road, Hagerstown, Maryland 21742</b>								
31. Date filed (Month, Day, Year) <b>FEB 08 1999</b>		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Clarence Albert Blackwell

2. Date of Death

February 02, 1999

3. Time of Death

3:03 P.M.

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

214-62-7555

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 28, 1909

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

520 Glenburn Avenue

10f. Zip Code

21613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Wesley Blackwell

18. Mother's Name (First, Middle, Maiden Surname)

Adelia Cain

19a. Informant's Name/Relationship (Type, Print)

Olivia M. Schunick

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1317 Colonial Avenue Cambridge MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel Cemetery

Date

2/06/99

20c. Location - City or Town, State

Cambridge, MD.

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

Henry Funeral Home P.A.  
510 Washington St. Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

b. Chronic Debilitated State

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

4 min

10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☒ Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D26385

29d. Date signed (Month, Day, Year)

2-4-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Franken 302 Collins Heights MD 21613

31. Date filed (Month, Day, Year)

FEB 4 1999

32. Registrar's Signature

[Signature]

State  
Registrar

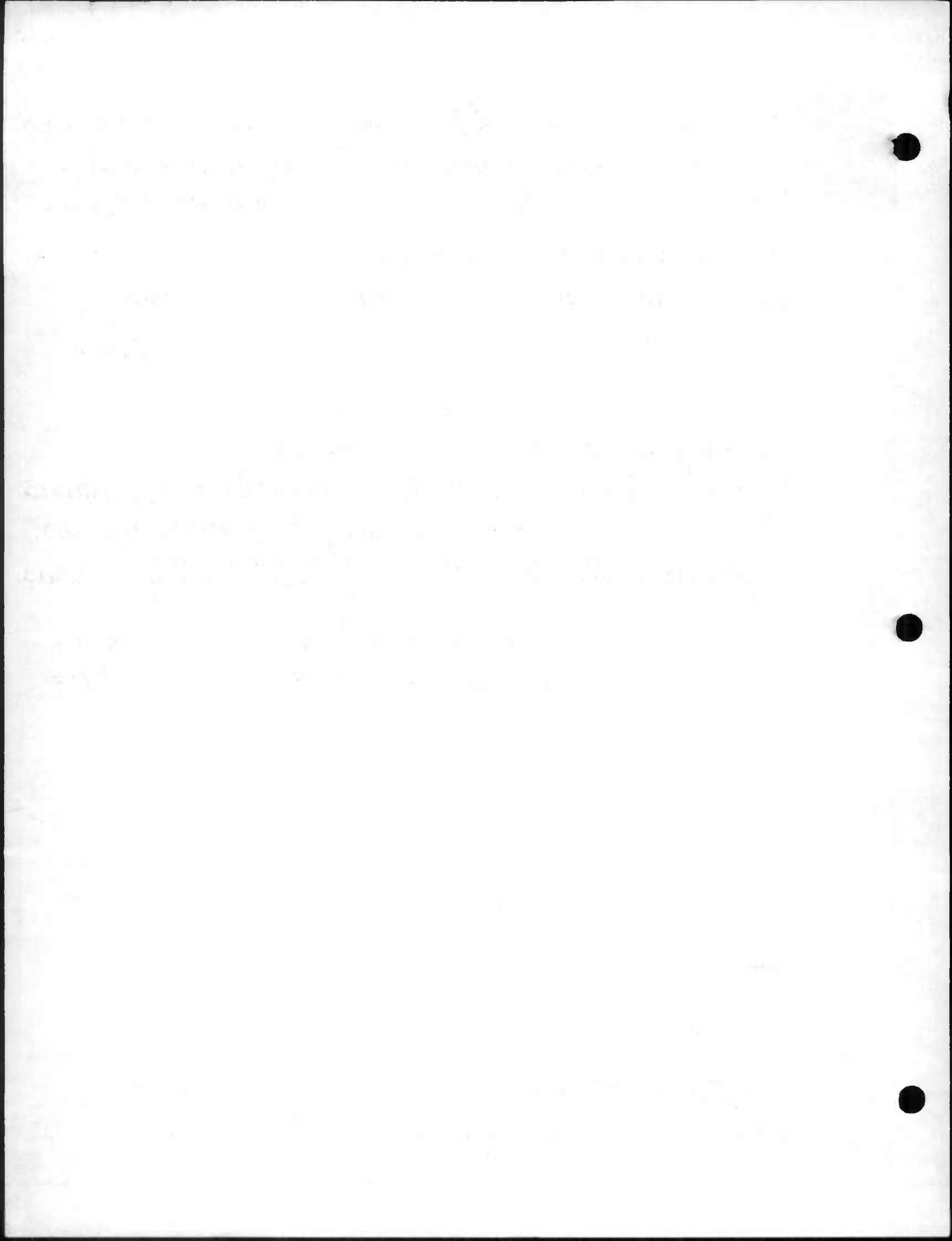
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020 toll permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04994

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thurman Philip Cline

2. Date of Death

FEBRUARY 6 1999 10:20 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217-12-1989

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 8, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Sharpsburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6705 Sharpsburg Pike

10f. Zip Code

21782

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates:

1943

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

David Frederick Cline

18. Mother's Name (First, Middle, Maiden Surname)

Beulah Catherine Bowers

19a. Informant's Name/Relationship (Type, Print)

Mary J. Cline/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6705 Sharpsburg Pike Sharpsburg, Maryland 21782

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greenlawn Memorial Park

Date

2-10-99

20c. Location - City or Town, State

Williamsport, Maryland

21. Signature of Funeral Service/Licensee

Osborne Funeral Home

425 S. Conococheague St. Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. SEPSIS

Due to (or as a consequence of):

HOURS

b. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

DAYS

c. LEFT CEREBROVASCULAR ACCIDENT W/RIGHT SIDED WEAKNESS

Due to (or as a consequence of):

DAYS

d. CORONARY ARTERY DISEASE

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

INSULIN DEPENDENT DIABETIC NEPHROPATHY

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Ceballos, MD

29c. License number

D25886

29d. Date signed (Month, Day, Year)

Feb. 6. 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LILIA CEBALLOS M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 08 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

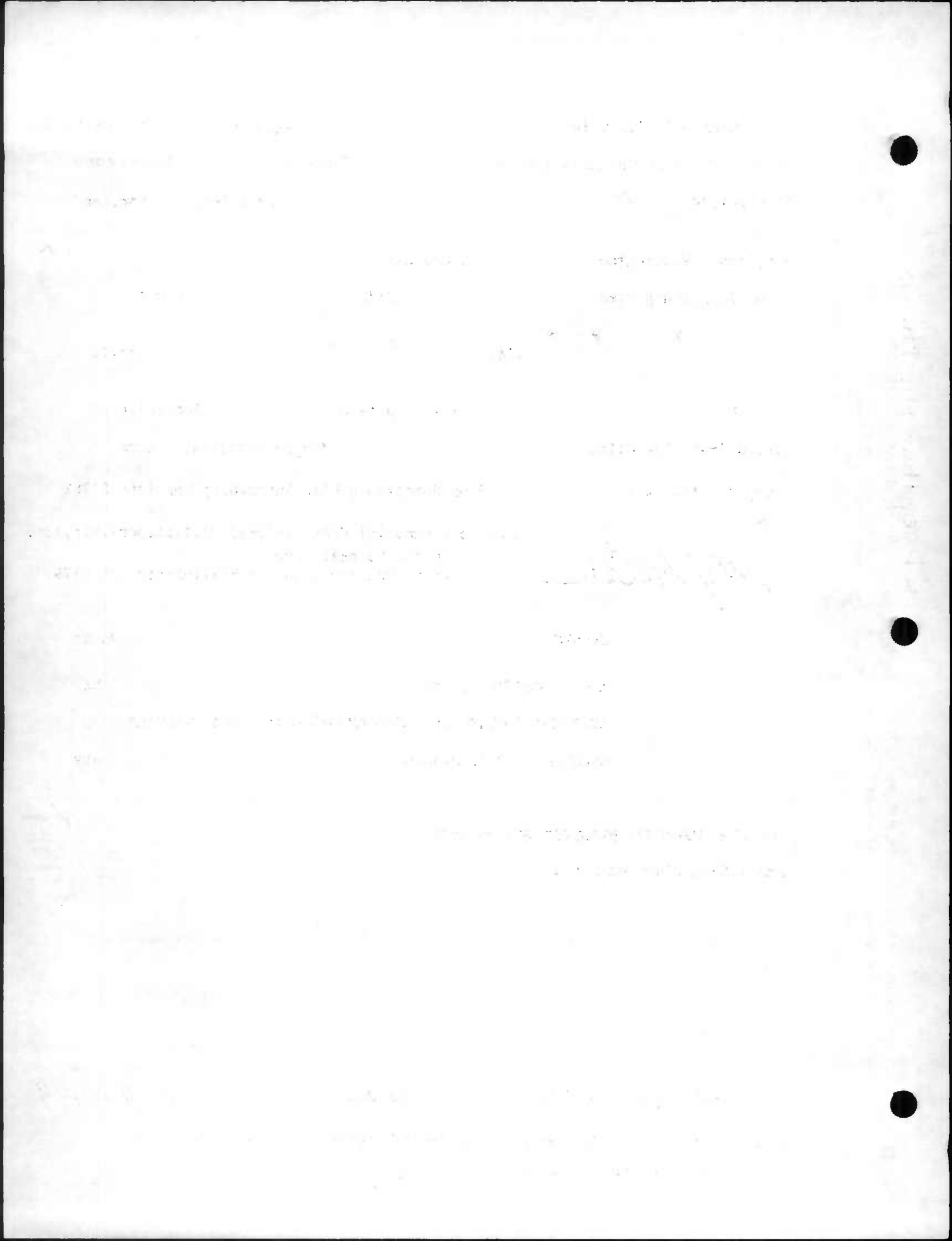
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Cline, Thurman Philip  
Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 04995

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Foster J. Cisney

2. Date of Death

February 06 1999

3. Time of Death

0245

Day Year

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

183-09-6269

6. Sex

15 M 20 F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

2/5/13

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Pa.

10b. County

Fulton

10c. City, Town or Location

McConnellsburg

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

524 N. Fifth St.

10f. Zip Code

17233

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
10 Yes 20 No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
10 Yes 20 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Grocery ; store owner

16b. Kind of Business/Industry

Retail Sales

17. Father's Name (First, Middle, Last)

Charles W. Cisney

18. Mother's Name (First, Middle, Maiden Summa)

Nannie Mae Flood

19a. Informant's Name/Relationship (Type, Print)

Beverly Cisney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12307 Walnut Dr., Conneaut Lake, Pa. 16316

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Union Cemetery

Date

2/10/99

20c. Location - City or Town, State

McConnellsburg, Pa

21. Signature of Funeral Service Licensee

Rodger Cornelius

22. Name and Address of Facility

Kelso-Cornelius Funeral Home, Inc.  
322 N. Second St., McConnellsburg, Pa.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a.

PNEUMONIA

Due to (or as a consequence of):

Cocaine Abuse disease

b.

Due to (or as a consequence of):

prostate vesicle disease

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

3 weeks

unknown

unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy  
performed?

10 Yes 20 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

10 Yes 20 No

25. Was case referred to medical  
examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

26. Place of Death (Check only one)

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending  
Investigation  
20 Accident 60 Could not be  
determined  
30 Suicide  
40 Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D47288

29d. Date signed (Month, Day, Year)

02-06-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr Iqbal 12821 Oak Hill Avenue Hagerstown Maryland

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 08 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Cisney, Foster J



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04996

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Arrie Anna Carter</b>				2. Date of Death Month <b>Feb</b> Day <b>4</b> Year <b>1999</b>		3. Time of Death <b>4:15PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Genesis ElderCare - The Pines</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>215-16-8906</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 24, 1924</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>412 Pine Street</b>				10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Processing Line Helper</b>		16b. Kind of Business/Industry <b>Seafood Industry</b>		
17. Father's Name (First, Middle, Last) <b>Oscar Tilghman, SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Beulah Major</b>				
19a. Informant's Name/Relationship (Type, Print) <b>John Carter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>412 Pine Street Cambridge, MD. 21613</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bethel Cemetery</b>		Date <b>2/10/99</b>		20c. Location - City or Town, State <b>Cambridge, MD.</b>		
21. Signature of Funeral Service Licensee <b>Janelle C. Henry</b>				22. Name and Address of Facility <b>Henry Funeral Home P.A. 510 Washington St. Cambridge, MD. 21613</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS</b> Due to (or as a consequence of): <b>b. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>c. INSULIN DEPENDENT DIABETES</b> Due to (or as a consequence of): <b>d. CEREBROVASCULAR ACCIDENT</b>								Approximate Interval Between Onset and Death <b>WEEKS</b> <b>YEARS</b> <b>YEARS</b> <b>MONTHS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b> <b>GOUT</b> <b>SEIZURE DISORDER.</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>H48241</b>		29d. Date signed (Month, Day, Year) <b>2/5/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DANIEL E. MAKAS, DO 508 IDLEWILD AVE EASTON, MD 21601</b>								
31. Date filed (Month, Day, Year) <b>FEB 9 1999</b>		32. Registrar's Signature <b>[Signature]</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04997

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NORMAN JAMES COSTON

2. Date of Death

Month Day Year  
02 07 1999

3. Time of Death

11:20 PM

4a. Facility Name (If not institution, give street and number)

PRMC

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

215 126 000

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
08/09/21

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Stockton

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1606 St. John Rd.

10f. Zip Code

21864

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck-driver

16b. Kind of Business/Industry

Poultry

17. Father's Name (First, Middle, Last)

Willie Purnell

18. Mother's Name (First, Middle, Maiden Surname)

Gussie Coston

19a. Informant's Name/Relationship (Type, Print)

Carolyn Brittingham

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1606 St. John Rd. Stockton Md. 21864

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Coolspring Cemetery

Date

2/13/99 Girdletree Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bernie Smith Funeral Home  
P.O. Box 331 - Pocomoke City, Md. 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Cardiovascular Disease  
CVA with Left Hemiparesis  
Essential Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

2-7-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DRIVE, SALISBURY, MD 21801

31. Date filed (Month, Day, Year)

FEB 11 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



100-1037

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 19b Per A.B. Film G768 2-18-99 rja

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Ellisworth Colmer Sr.

2. Date of Death  
Month Day Year

2 3 99 11:30

3. Time of Death

4a. Facility Name (If not institution, give street and number)

1694 Pine Swamp Road

4b. City, Town, or Location of Death

Barton, Md

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

217-14-4354

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

11/29/21

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Garrett

10c. City, Town or Location

Barton

10d. Inside City Limits

☐ Yes ☐ No

10e. Street and Number

1694 Pine Swamp Rd

10f. Zip Code

21521

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Logger

16b. Kind of Business/Industry

Forestry

17. Father's Name (First, Middle, Last)

Paul B. Colmer

18. Mother's Name (First, Middle, Maiden Surname)

Stella Warnick

19a. Informant's Name/Relationship (Type, Print)

Eleanor Colmer wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1694 Pine Swamp Road, Barton, Maryland 21521

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☒ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Anatomy Board

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Leukemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Suicide ☐ Could not be determined  
☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

023979

29d. Date signed (Month, Day, Year)

2/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

311 N. 4th St Oakland, Md. 21550

31. Date filed (Month, Day, Year)

FEB 18 1999

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 2 of 2  
Date: 10/10/2010  
Time: 10:10 AM

10/10/2010 10:10 AM  
10/10/2010 10:10 AM

10/10/2010 10:10 AM  
10/10/2010 10:10 AM

10/10/2010

003259

311 N. 1st St. (Oakland, CA 94612)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 04999

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FOREST CRAIG DENNIS				2. Date of Death Month Day Year JAN. 24, 1999		3. Time of Death 0712 AM	
	4a. Facility Name (If not institution, give street and number) ST. MARY'S HOSPITAL E.R.				4b. City, Town, or Location of Death LEONARDTOWN		4c. County of Death ST. MARY'S	
Funeral Director	5. Social Security Number 227-13-5648	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 35 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11-28-63		9. Birthplace (State or Foreign Country) SC
	Usual Residence of Decedent							
10a. State MD		10b. County ST. MARY'S		10c. City, Town or Location CALLAWAY			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 20861 HARLEQUIN LANE				10f. Zip Code 20620		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SYSTEMS ANALYST			16b. Kind of Business/Industry COMPUTER DESIGNS	
17. Father's Name (First, Middle, Last) FOREST GEORGE DENNIS				18. Mother's Name (First, Middle, Maiden Surname) ELLEN-MARIE HERR				
19a. Informant's Name/Relationship (Type, Print) PENNY JEAN SURBER DENNIS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20861 HARLEQUIN LANE, CALLAWAY, MD 20620				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) ROSELAWN BURIAL PARK		Date 1-27-99		20c. Location - City or Town, State MARTINSVILLE, VIRGINIA
21. Signature of Funeral Service Licensee <i>Michelle Jones</i>				22. Name and Address of Facility NORRIS FUNERAL SERVICES PO BOX 5501, MARTINSVILLE, VA 24115				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>PULMONARY THROMBOEMBOLISM</i> Due to (or as a consequence of):  b. <i>DEEP LEG VEIN THROMBOSIS</i> Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24e. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Theresa Anne Gault</i>				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JAN. 25, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY SAITA D. KOSOW 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) FEB 3 1999				32. Registrar's Signature <i>Beverly S. Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 05000

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Ross Dupuis</b>				2. Date of Death Month <b>Feb.</b> Day <b>7</b> Year <b>99</b>				3. Time of Death <b>1145</b>													
	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>				4c. County of Death <b>Washington</b>													
Funeral Director	5. Social Security Number <b>368-32-3081</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11-09-32</b>		9. Birthplace (State or Foreign Country) <b>Michigan</b>													
	10a. State <b>PA</b>				10b. County <b>Franklin</b>		10c. City, Town or Location <b>Shippensburg</b>															
10d. Inside City Limits <b>1</b> Yes <b>2</b> No				10e. Street and Number <b>5548 Roxbury Road</b>				10f. Zip Code <b>17257</b>		10g. Citizen of What Country? <b>U.S.A.</b>												
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>1961-1984</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>													
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 yrs.</b> College (1-4 or 5+) <b>2 yrs.</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Personnel</b>				16b. Kind of Business/Industry <b>U.S. Army</b>														
17. Father's Name (First, Middle, Last) <b>William J. Dupuis</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Donna M. Ross</b>																
19a. Informant's Name/Relationship (Type, Print) <b>Wilma K. Dupuis Wife</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5548 Roxbury Road Shippensburg, PA 17257</b>																
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Indiantown Gap National Cemetery</b>				20c. Location - City or Town, State <b>West Hanover Twp., Lebanon County, PA</b>		20d. Date <b>2-12-99</b>												
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility <b>Fogelsanger-Bricker Funeral Home 112 W. King St. BOX 336, Shippensburg, PA 17257</b>																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Pneumonia</b></td> <td rowspan="4">           Due to (or as a consequence of):             Due to (or as a consequence of):             Due to (or as a consequence of):         </td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>5 days</b>   <b>1 month</b>   <b>unknown</b> </td> </tr> <tr> <td>b.</td> <td><b>Respiratory failure</b></td> </tr> <tr> <td>c.</td> <td><b>Arterial hypertension</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>												Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Pneumonia</b>	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>5 days</b>  <b>1 month</b>  <b>unknown</b>	b.	<b>Respiratory failure</b>	c.	<b>Arterial hypertension</b>	d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Pneumonia</b>	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>5 days</b>  <b>1 month</b>  <b>unknown</b>																		
	b.	<b>Respiratory failure</b>																				
	c.	<b>Arterial hypertension</b>																				
	d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																						
23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown																						
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No																						
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No																						
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)																		
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred												
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
29b. Signature and title of certifier <i>[Signature]</i> <b>MD</b>				29c. License number <b>P47288</b>				29d. Date signed (Month, Day, Year) <b>02, 07, 1999</b>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Shaheen Iqbal M.D. 12821 Oak Hill Ave Hagerstown, MD 21742</b>																						
31. Date filed (Month, Day, Year) <b>FEB 10 1999</b>				32. Registrar's Signature <i>[Signature]</i>																		

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